# Petition

81-5534

NO.

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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

JOHN E. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

PETITIONERS,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

RESPONDENTS.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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On the Petition

## QUESTIONS PRESENTED FOR REVIEW

1. When a state subjects confined mental patients to drugs that often cause permanent deformity and persistent mental torment, what kind of hearing or other procedural consideration must be afforded under the Fourteenth Amendment to the United States Constitution?

2. What substantive limitations does the Fourteenth Amendment to the United States Constitution impose on a state's power to administer psychotropic drugs to a person who will thereby suffer serious physical and mental damage?

3. When should a confined mental patient, being drugged by the state, be deemed to have waived procedural and substantive rights under the Fourteenth Amendment to the United States Constitution?

4. Assuming that the Fourteenth Amendment includes procedural and substantive limitations on drug use in state hospitals, may state officials be enjoined to institute more rigorous procedures and to apply more exacting substantive standards because of their proven misuse of drugs, poor fact-finding, and tolerance of serious drug-caused harms?

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IN THE SUPREME COURT OF THE UNITED STATES

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No. _____

JOHN E. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

Petitioners

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

Respondents

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The petitioners respectfully request that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Third Circuit entered in this case on July 9, 1981.

## OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit, reported at 653 F. 2d 836, is included with this petition as Appendix A. That opinion was subsequently amended on July 20, 1981 and that amendment is included herewith as Appendix B.[1] The petitioners here filed a petition for

[1] The Court of Appeals had earlier denied the state's request for a stay of the district court order. That decision is included with this petition as Appendix C.

certiorari under United States Supreme Court Rule 18 before the Third Circuit decision. The Supreme Court denied that request for pre-judgment certiorari, 49 U.S.L.W. 3911 (No. 80-6660). The order and decision of the United States District Court for the District of New Jersey is reported at 476 F. Supp. 1294 (D.N.J. 1979) and is included with this petition as Appendix D. The order and decision of the United States District Court for the District of New Jersey denying a stay pending appeal, is reported at 481 F. Supp. 552 (D.N.J. 1979) and is included with this petition as Appendix E. An earlier opinion of the United States District Court for the District of New Jersey in Rennie v. Klein is reported at 462 F. Supp. 1131 (D.N.J. 1978) and is included with this petition as Appendix F.

## JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on July 9, 1981 and is included as Appendix G to this petition. This petition for certiorari is being filed within 90 days of the date of that judgment. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

## CONSTITUTIONAL PROVISION INVOLVED

UNITED STATES CONSTITUTION, AMENDMENT XIV, SECTION 1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

## STATEMENT OF THE CASE

The petitioners represent a class of adult New Jersey mental patients, about five thousand in number, who are confined in five state psychiatric hospitals. They complained about the powerful drugs (called "psychotropic ," "antipsychotic," or "neurolpetic" drugs) that state hospitals routinely administer to them.[2]

The District Court entered a remedial order requiring additional procedural and substantive consideration by the state before it drugged non-consenting class members. The United States Court of Appeals for the Third Circuit, in banc, agreed that involuntary state mental patients had constitutional rights in drugging matters, but the Third Circuit modified the District Court's order substantially.[3]

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[2] These chemical agents are commonly used in psychiatric facilities. The same drugs are at issue in Rogers v. Okin, 634 F. 2d 650 (1st Cir. 1980), cert. granted ____ U.S. ____, 101 S. Ct. 1972, 68 L. Ed. 2d 293 (1981).

[3] In form the District Court order was a preliminary injunction. The hearings, however,". . . were as extensive as would be expected in the case of a permanent, rather than a preliminary, injunction" and the District Court "prepared a comprehensive opinion that demonstrated complete familiarity with the issues and applicable law . . . ." Rennie v. Klein, 653 F. 2d 836 at 841 (3rd Cir. 1981), Appendix A, p. 9a. These considerations combined with the scope of the District Court order, led the Third Circuit to employ on appeal " . . . a more searching review than is customarily provided for preliminary injunctions." 653 F. 2d at 841, Appendix A, p. 10a. Also, it should be noted that the parties had desired in the District Court to invest the injunction with all possible finality. Other issues remained in the case, including a variety of non-drug related claims and drug-related claims by a class of minor patients. Thus, the District Court noted -- a few weeks before issuing the preliminary injunction -- that "the Court will not consolidate [the hearings on preliminary and final relief] as was discussed . . . on the last day of the most recent hearing, even though I am led to understand counsel would consent to such a consolidation." Third Circuit Appendix, p. 2330a Compare the Third Circuit's discussion of this issue concluding that defense "counsel approved the concept [of consolidation] but stated he lacked the authority to consent. In the absence of clear agreement between the litigants, the [District] Court declined to consolidate." 653 F. 2d at 841, Appendix A, p. 9a. Petitioners believe that the defendants informed the District Judge informally of their willingness to consolidate, and that is why, after all the testimony had been taken, the District Court mentioned counsels' willingness to consent.

(footnote continued)

The District Court record is extensive and detailed. As the price of using drugs, New Jersey state physicians accepted serious harms to the patients -- harms caused by unintended but common drug side effects. In addition, physicians' fact-finding about drug harms was poor, so poor that extremely bizarre, permanent drug-induced motor dysfunctions were usually not noticed. Also, state hospitals as a rule administered drugs despite patients' lack of competent consent or outright resistance.

The drugs' unintended side effects are well established. Many patients take on permanent, grotesque postures accompanied by loss of motor control; this is the condition that is called tardive dyskinesia and it varies in severity from patient to patient. Other patients experience mental discomfort or even torment, though these conditions are said to be temporary. Zombiism -- a stupor more profound than oversedation -- is a common side effect. So is a condition resembling Parkinson's disease. The drugs may have other serious effects on physical health, though the extent of some such effects are debatable.[4] Sexual functioning is often impaired as long as the drugs are administered. All these conditions -- and others -- are abundantly represented in the Rennie trial record of drug-induced harms in New Jersey hospitals. See Appendix D, pp. 7d-8d; Appendix F, pp. 9f-11f; see also Appendix H.

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[3] (continued)
It would be fair to say that the Third Circuit reviewed the district court order as though it had been a final injunction. It is true that the Third Circuit's majority opinion said that " . . . it is a preliminary and not a permanent injunction that we modify . . . [so that the] district court retains jurisdiction over these proceedings and may consider any future charge that defendants refuse to recognize the constitutional right upheld here or are not complying with them . . . [state's intramural procedures] as incorporated in the modified decree." 653 F. 2d at 851, Appendix A, p. 31a. But petitioners believe that the district court and the Third Circuit would have considered "future cha ge[s]" of non-compliance in just the same way had the injunction been final. The enforcement proceedings would simply have been styled differently. Surely, the district court would violate the appellate mandate here if it modifies the Third Circuit's "interim" injunction in any important respect unless the defendants themselves first violate that injunction. That, petitioners believe, is characteristic of a final order.

[4] For example, one non-psychiatrist physician testified as to a range of other side effects such as coma, dehydration, and increased risk of pneumonia. Appendix H, pp. 218h-253h (Deposition of Dr. LoPrete).

The hospitals' willingness to tolerate drug side-effects was associated with poor fact-finding on occasion.[5] In some cases it appears that the hospital would have attempted to alleviate the side effect, had the side effect been recognized in the first place. But in a greater number of cases, physicians apparently refused to acknowledge the side effect because they wished to continue using the drug -- despite the harm being caused -- without hearing patients', relatives' or third-parties' reproaches. See Appendix D, p. 13d. And in still other cases, doctors acknowledged the side effects but deemed them unimportant.[6]

It bears emphasis that poor fact-finding often resulted from -- rather than contributed to -- the state doctors' tolerance of severe side-effects. Since tardive dyskinesia is generally regarded to be the drugs' most serious common side effect, the state's handling of this condition is an apt illustration of the point. Hospital medical directors testified that perhaps twenty-five per cent of New Jersey patients suffered from the paroxyms of tardive dyskinesia, the condition being somewhat more common among elderly patients and somewhat less common among the younger hospital inmates. See Appendix D, pp. 7d-8d. Yet state doctors literally never diagnosed the condition or acknowledged its existence: Until the trial of this case, New Jersey's official public position was that not one patient had tardive dyskinesia. See Third Circuit Appendix pp. 779b, et seq., and 264 et seq.; see also, id. p. 1500a. That left the actual patient movements caused by tardive dyskinesia to be accounted for. Usually patient paroxisms were simply ignored -- never charted -- as though they did not

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[5] An unstated premise of the Third Circuit opinion may be that state physicians' tolerance of side effects resulted from the absence of honest fact-finding. The district court's findings were otherwise. The point, however, is not discussed specifically in the Third Circuit majority opinion.

[6] As one of the state's expert witnesses testified: "There is . . . some evidence that a significant percentage, perhaps even a majority of patients with Tardive Dyskinesia don't know it if it is pointed out to them, are not troubled by it . . . but it is to say that a fair number of patients who have the condition don't consider it a problem to themselves." Third Circuit Appendix, pp. 1791a-1792a (Testimony of Dr. Rachlin).

exist. If the patient or outsiders called attention to the bizarre movements, two other courses of action were pursued. Either the patient was said to be faking or else the movements were attributed to nervousness or mental illness. See Appendix D, p. 11d. Permanent drug side effects were ignored, precisely because of their seriousness and the implications for the future use of drugs.[7] See Third Circuit Appendix, pp. 779b, 264b and 1500a, id. pp. 1365a-1366a; Appendix H, pp. 47h-51h and 63h-65h; Appendix D, pp. 11d, 13d; see generally Appendix D, pp. 7d-9d. The doctors' unanimous refusal to acknowledge over a period of years their drugs' most serious side effect cannot reasonably be accounted for in terms of occasional lapses in observation, diagnosis or fact-finding.

There is a related point. It may be that in some cases the state would not continue its drugging of a patient found to be suffering from tardive dyskinesia or to be at great risk of developing the disorder. Were that so, improved fact-finding would have affected the outcome. But in other such cases drugging would continue. New Jersey insists on its prerogative of causing tardive dyskinesia -- or any drug side effect for that matter -- in order to further legitimate state purposes. The most serious threat of tardive dyskinesia does not preempt the state's power to drug, according to state officials. And one may fairly conclude from the record that state physicians, in the greatest number of cases, would feel warranted in causing tardive dyskinesia even if they had to acknowledge the side effect.

In addition, tardive dyskinesia is actually only one of many side effects of these drugs. But testimony showed that these other side effects were also generally overlooked. The state never denied the existence of many of these conditions in the abstract. But neither did the state concede that inflicting these side effects implicated substantive limitations on state action under the Fourteenth Amendment.

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[7] On occasion, patient complaints provoked staff retaliation in the form of a still more distressing drug regime. See generally, Appendix D, pp. 9d-13d; 16d.

There is a final point about the relationship between poor fact-finding and the state physicians' tolerance of side effects, as disclosed by the record. There is no basis in petitioners' view for concluding that physicians' lack of opportunity to observe patients contributed to these problems. The patients who testified had been repeatedly observed by physicians, nurses and attendants. These staff made fairly frequent entries in patient charts. Instead, the record suggests that despite staff's opportunity to observe patients, serious side effects were tolerated and ignored.[8]

This lawsuit began as an individual action by one mental patient, John Rennie. See Appendix F. A class action complaint and a complaint in intervention were later filed, after which the district court certified classes and subclasses encompassing every adult or minor patient in a New Jersey state mental hospital -- classes numbering about five thousand members at any one given time and fifteen thousand members in the course of a year. The district court's jurisdiction was invoked under 28 U.S.C.A. §1343.

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[8] The American Psychiatric Association's amicus brief for the Court of Appeals described the Rennie proofs as demonstrating "a serious problem of misuse of medication in New Jersey state hospitals" where drugs were used, in effect, to promote "the kind of concerns for security that characterize a prison." Brief for the American Psychiatric Association as amicus curiae at p. 19. The APA went on to argue that understaffing assuredly has serious effects on other aspects of hospitalization, there is no reason to believe that more staff results in less toleration of side effects. Petitioners believe therefore that little, if any evidence in the record, supports the APA theory; the district court did not adopt that view, and the Third Circuit did not address the issue. The physicians' prerogative to inflict side effects was not questioned by the APA, though the APA did argue that side effects could be avoided -- and should be avoided -- more often than was the case in New Jersey.

The state officials argued that petitioners' evidence related to isolated instances; however, the district court's findings were not seriously questioned in the Third Circuit and petitioners believe that the record gives a systematic, accurate and broad-based picture of drug use in New Jersey state hospitals. The American Psychiatric Association appears to have agreed that unacceptable drug practices were characteristic of New Jersey institutions.

The district court heard testimony on a total of thirty-three days over a period of a year-and-a-half. The witnesses included patients subject to drugging, research psychiatrists[9] and state administrators and physicians.

Saying that "the constitution can and does prevent those who have suffered so much at the hands of nature from being subject to further suffering at the hands of man," the United States District Court for the District of New Jersey entered a broad remedial order. Appendix D, p. 25d. This decree was grounded in the Fourteenth Amendment and had both substantive and procedural aspects. The district court's mandated procedures were described in the language of administrative law, but basically entailed peer review of drug decisions at different levels of the medical bureaucracy in state hospitals. Carried out to the hilt, the system of peer review culminated in a second physician's medical opinion. However, the district court held that this second physician could not be a regular, full time hospital employee. Another distinctive feature of the district court's procedures was its provision for "patient advocates" -- "attorneys, psychologists, social workers, registered nurses or paralegals" hired by the hospitals. Appendix D, p. 34d. These employees would assist patients in dealing with hospital doctors during drug disputes. Also, the "advocates" had some responsibility for the interests of "functionally" incompetent patients, people too feeble in fact to reflect on the benefits and harms of drugs they were receiving.

The decree mandated substantive standards as well as procedures. These standards were phrased in terms of "four factors" that, in combination, would be decisive of the question of whether drugs could be forced on an unwilling patient. The four factors were the patient's dangerousness, his mental capacity, the existence of less restrictive or less harmful treatments, and the risk of permanent side effects. At one point, the district court apparently believed that a patient "likely to contract tardive dyskinesia

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[9] Appendix H reproduces the testimony of four patients, one relative, one expert witness and one non-psychiatrist physician.

through renewed administration of psychotropic drugs" could not be forced to take drugs, on that account alone. Appendix F, p. 26f. However, it is not clear that that hard and fast rule was incorporated in the court's eventual decree.

The parties cross-appealed to the United States Court of Appeals for the Third Circuit, which heard and decided the case in banc.[10] While the Third Circuit found forced drugging to implicate constitutional liberty interests, it also held that the state hospitals' intramural fact-finding procedures satisfied the Fourteenth Amendment. These intramural, peer-review procedures do not require either independent psychiatric evaluations or patient advocates; nor do the procedures affect patients too feeble or too frightened to complain about drugs. Neither do the state's procedures call for written disclosure of drug side effects to patients, as the district court's decree had done.

## Reasons for Granting the Writ

1. The Fourteenth Amendment questions presented in Rogers v. Okin, 634 F. 2d 650 (1st Cir. 1980), cert. granted, --U.S.--, 101 S. Ct. 1972, 68 L. Ed. 2d 293 (1981) ought to be decided only after the Court has considered the factual record in Rennie, which depicts actual drug practices in state mental hospitals.

Certiorari has been granted in Rogers v. Okin, 634 F. 2d 659 (1980), cert. granted, --U.S.--, 101 S. Ct. 1972, 68 L. Ed. 2d 293 (1981). One issue

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[10] Earlier, a three judge panel heard the appeal. The panel prepared an opinion, but "its filing was withheld pending the filing of the . . . [Third Circuit's] en banc opinion in Romeo v. Youngberg, 644 F. 2d 147 (3rd Cir. 1980)" [cert. granted, --U.S.--, 101 S. Ct. 2313 (1981)], Rennie, 653 F. 2d at 862, n.15, Appendix A, p. 55a (Garth, J. concurring). After the Third Circuit decided Romeo in banc, Rennie was ordered reheard before the entire Third Circuit bench.

there is the procedural due process -- if any -- due patients subject to forced drugging on a state mental hospital ward. Rennie raises the same issue. However, Rennie offers a far more detailed record than Rogers does of actual drug practices. Such a record is important because of the legal questions involved.

"Where claims that the state is acting in the best interests of an individual are said to justify reduced procedural and substantive safeguards, this Court's decisions require that they be candidly appraised." O'Connor v. Donaldson, 422 U.S. 563, 586 (1975) (Mr. Chief Justice Burger concurring) (internal quotations omitted). Here, states claim the prerogative of causing patients permanent physical harm via drug side effects in patients' best interests. This presents the "best interests" dilemma in its starkest form, and the states' arguments therefore surely deserve the most "candid appraisal" possible.

The Rogers record is scanty in vital areas. Proofs there seemingly focused on a handful of patients known to doctors in advance. There appears to be no systematic picture of drug usage. Moreover, not one in this handful of patients in Rogers developed a serious drug side effect.[11] Therefore, one cannot tell whether doctors would have acknowledged the side effect or whether they would have adjusted drugging because of it. The states' claims cannot be "candidly appraised" given such a record. By contrast the record in this case depicts serious side effects actually suffered. The record also deals with faulty fact-finding with respect to side effects, the doctors' willingness to tolerate such serious side effects among patients, as well as the hospitals' unwillingness to respond to valid complaints about drug distress and harm.

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[11] Nonetheless, it is clear that Massachusetts mental patients suffer tardive dyskinesia and other serious side effects. One Rogers ward nurse later told an independent researcher that "it seemed that a very high percentage of patients exhibited at least one . . . symptom of [tardive dyskinesia]." See Third Circuit Appendix, p. 580b, 640b. This quotation is taken from a study of the Rogers wards introduced into evidence during the Rennie trial, by the Rennie defendants (state officials). Judging from the Rogers opinions, no such proofs were developed during the Rogers trial itself.

A second factor enhances the importance of a factual record in these cases. The issues arise in an arcane, even alien social context. By contrast, In re Gault, 387 U.S. 1 (1967) evaluated paternalistic claims set in a familiar setting -- there, a courtroom. In Ingraham v. Wright, 430 U.S. 651 (1977) the issue was corporeal discipline of school children. Although the practice of corporal punishment is anomalous in today's jurisprudence -- just as drugs are -- the public school context is familiar and public schools are open to public view. But mental hospitals are unfamiliar forbidding institutions. Against this background, without a fully developed record, one is disadvantaged in attempting to understand the institutional environment and the institutional imperatives that give meaning to bare, abstract facts about drugs.

One might design substantive and procedural safeguards under the Fourteenth Amendment appropriate to drugs' potential for harm under the worst possible circumstances. This would presume states never act in the "best interests" of individuals. The Court has rejected that approach. See Parham v. J.R., 442 U.S. 584 (1979). But it is equally wrong to determine the issue instead by focusing on the most benign imaginable meaning of words like "doctor," "drug," "patient," and "hospital." Notwithstanding such a benevolent nomenclature, the states may be doing serious damage to procedural and substantive constitutional limitations. This is a question of fact that cannot be answered on the record in Rogers.

Further, Rennie presents related issues more clearly than Rogers does. First, is the question of whether some drug side effects, under some circumstances at least, exceed the Fourteenth Amendment's substantive limitations on the severity of state actions. Since no Rogers patient was actually proved to suffer a serious side effect, this issue is not presented squarely in that case. Second, is the question of waiver. What if a patient is too feeble or incompetent to understand the effects of drugs?

A final advantage of Rennie as a means of approaching these issues has to do with the opinions below. The district court's opinion addressed

practical remedial issues that the Rogers opinions did not. It seems likely that the First Circuit remand in Rogers contemplated precisely the type of remedial study that has already been done in Rennie.[12] In this sense, too, the Rennie record is further developed than Rogers.

Petitioners believe that the importance of these issues combined with their unusual quality and the alien social context, warrants the fully developed record that is available in Rennie.

2. The decision below raises important questions about the federal courts' remedial responsibilities in public psychiatric hospital litigation.

In effect, the Third Circuit decided that the district court should have framed its decree as though no abuses in state hospital drug practices had been proven. Instead, the district court should have simply ordered the hospitals to comply with the most minimal facially constitutional requirements. In short, the hospitals' actual past drug practices and their devastating effects ought to be irrelevant to the decree. Yet the district court opinion develops at length the reason why such procedures, which are appealing on their face, would be insufficient given the history of drug use in New Jersey.

Petitioners believe that the procedures deemed minimally adequate by the Third Circuit are, as a matter of law, inadequate under the Fourteenth

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[12] Another difference between Rennie and Rogers should be noticed, one having to do with the state law background to the cases. Massachusetts commitment proceedings -- which affected the patients in the Rogers case -- may, under some circumstances, constitute a judicial "determination of incapacity." That is, committed patients would be found incompetent to make treatment decisions at the time of commitment, an integral aspect of the commitment procedures. Rogers, 634 F. 2d 650, 657. The Rogers hospital officials argued that commitment always equaled a determination of incapacity under Massachusetts law. The First Circuit disagreed, reading Massachusetts law to permit commitment based on incapacity but not to require incapacity in every case of commitment. The New Jersey law backdrop in Rennie is irrelevant and the New Jersey Supreme Court has definitely proclaimed this interpretation of state statutes. See New Jersey Court Rule 4:74-7; Pressler, Annotated New Jersey Court Rules, Comment to Rule 4:74-7 (1980); In re Geraghty, 68 N.J. 209 (1975); Coll v. Hyland, 411 F. Supp. 905 (D.N.J. 1976) (three judge court).

Amendment. But if the Third Circuit is correct, the question remains whether petitioners are entitled to a broader remedy because of the abuses that they proved. Indeed, this question may take a sharper form. If this Court should determine, for example, that state mental patients have no constitutional rights in drug matters -- except for the right to be free from "punishment" -- would district courts be empowered to fashion equitable relief on a record of abuse like that amassed in Rennie? If so, what type of relief would be appropriate?

These questions warrant the Court's attention if only because of the severity of the consequences to patients when drugs are misused. Furthermore, petitioners believe drug problems are different enough from other mental hospital issues to justify separate treatment. It might be tempting to suppose that broad "right to treatment" decrees would always take care of drug problems in their wake. But broad "right to treatment" decrees have simply not been passed upon by this Court, and their status is therefore suspect. More to the point, it is far from obvious that a typical "right to treatment" decree alleviates mental hospital misuse of drugs. The opposite may even be true. These right to treatment decrees have put a premium on shorter hospitalizations and more outpatient non-hospital treatment. Drugs have been essential in this project, and this may have actually raised state officials' tolerance for serious side effects.

Respectfully submitted,

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PUBLIC ADVOCATE

Sheldon Gelman, Esq.
J. Benedict Centifanti, Law Clerk

On the Petition

Date: October 7, 1981

NO. 81-5534

RECEIVED
OCT 7 1981
OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

JOHN E. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

Petitioners

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNICK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

Respondents

MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

The petitioner, Eugenio Burgeos, asks leave to file the attached petition for writ of certiorari without prepayment of costs and to proceed in forma pauperis. Petitioner's affidavit in support of this motion is attached hereto. Leave to proceed in forma pauperis was not sought in any court below.

Eugenio Burgeos

AFFIDAVIT

I, Eugenio Burgeos, being first duly sworn according to law, depose and say that I am one of the petitioners in the above-entitled case; that I am presently a patient at Ancora Psychiatric Hospital, Winslow Township, New Jersey; that in support of my motion to proceed without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said case or to give security therefor and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of proceeding in this Court are true.

1. Are you presently employed? No

   a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

   b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received. Unknown

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividents, or other source? No

   a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account? No

   a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable properly (excluding ordinary household furnishings and clothing)? No

   a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons. None

I understand that a false statement or answer to any question in the affidavit will subject me to penalties for perjury.

Eugenio Burgeos

Subscribed and Sworn to before me

this 30 day of September, 1981

Judy Cracker

Judy Cracker
Notary Public of New Jersey
My commission expires 2/9/82

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Petitioners

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

Respondents

ATTORNEY'S AFFIDAVIT IN SUPPORT OF PETITIONER'S MOTION TO PROCEED IN FORMA PAUPERIS

Michael L. Perlin, being of full age, upon his oath, does depose and say:

1. I am a member of the bar of the State of New Jersey and of the United States Supreme Court.

2. I am filing this affidavit in support of the petitioner's motion for leave to proceed in forma pauperis before this court in that he is not able to prepay fees or costs or otherwise pay the cost of this case.

3. I am the Director of the Division of Mental Health Advocacy of the Department of the Public Advocate of the State of New Jersey, appointed pursuant to N.J.S.A. 52:27E-21 et seq.

4. The Division of Mental Health Advocacy was established, pursuant to state statute, to provide legal representation in individual and class actions to "indigent mental hospital admittees" who do "not

have the present financial ability to secure competent legal representation and to provide all other necessary expenses of representation." N.J.S.A. 52:27E-23.

5. The Division of Mental Health Advocacy has provided legal representation for members of appellants' class -- "indigent mental hospital admittees" in five New Jersey state psychiatric institutions -- in this matter in the Federal District Court of New Jersey and in the Third Circuit Court of Appeals since the case was first filed on December 22, 1977.

6. In the course of the Federal District Court's initial decision in this matter, Rennie v. Klein, 462 F. Supp. 1131, 1147 (D.N.J. 1978), the trial judge noted specifically:

> Patients are entitled to a lawyer to assist them. Counsel is necessary to cope with the problems of law, to make skilled inquiry into the facts, and to insure proper procedures. (citations omitted) It is clear in this case that without the tireless efforts of Mr. Gelman and his staff at the Public Advocate's Office, Mr. Rennie could not effectively have made an argument before a factfinder and brought his case before this court. (citation omitted).

7. Leave to proceed in forma pauperis was not sought in any court below because it was unnecessary to print the papers under the applicable rules of the lower court.

8. I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Michael L. Perlin

Sworn and subscribed to
before me this 7th day
of October 1981.

Elaine M. Wieczkowski
Notary Public of New Jersey
My commission expires 10/28/85

# Appendix

# 1

81-5534

NO.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

JOHN E. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MAY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

PETITIONERS,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

RESPONDENTS.

APPENDICES A TO G TO PETITION FOR WRIT OF CERTIORARI

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STANLEY C. VAN NESS
PUBLIC ADVOCATE

Sheldon Gelman, Esq.
J. Benedict Centifanti, Law Clerk

On the Petition

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

---

Nos. 79-2576 and 79-2577

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JOHN E. RENNIE, Plaintiff on behalf of himself and all others similarly situated, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI, Intervenors, on behalf of themselves and all other similarly situated,

*Appellants/Cross-Appellees,*

*v.*

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

*Appellees/Cross-Appellants.*

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APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

(D.C. Civil No. 77-2624)

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Argued April 22, 1980

Before: ALDISERT, WEIS and GARTH,
*Circuit Judges*

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Appendix A 1a

Reargued In Banc May 12, 1981

Before: SEITZ, *Chief Judge*, ALDISERT, ADAMS, GIBBONS, HUNTER, WEIS, GARTH, HIGGINBOTHAM and SLOVITER, *Circuit Judges*

(Opinion filed July 9, 1981)

---

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Attorney General of New Jersey

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*Cross-Appellants*

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*Alliance for the Liberation of Mental Patients*

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## OPINION OF THE COURT

WEIS, *Circuit Judge.**

This appeal requires us to define the legal rights of the mentally ill with respect to the care and treatment supplied by the state. We hold that mental patients who are committed involuntarily to state institutions nevertheless retain a constitutional right to refuse antipsychotic drugs that may have permanently disabling side effects. The state may override that right when the patient is a danger to himself or others, but in non-emergency situations must first provide procedural

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* Chief Judge Seitz, and Judges Aldisert, Adams, Gibbons, Hunter, Garth, Higginbotham, and Sloviter join in sections II(A) (State Law liberty interest), and II(B) (Constitutional liberty interest), of the majority opinion. Chief Judge Seitz, and Judges Aldisert, Adams, Hunter, Garth, Higginbotham, and Sloviter also join in sections I (Scope of Review), III (Due Process standard), and IV (Decree). Judges Adams, Gibbons, Higginbotham, and Sloviter join in section II(C) (Least intrusive means).

due process. We further determine that the informal administrative procedures established by New Jersey meet constitutional standards, and accordingly, modify a district court injunction that required a formal adversary hearing and other measures before a patient's refusal can be overriden.

John Rennie has been a patient at the Ancora Psychiatric Hospital, a state institution in New Jersey, on numerous occasions since 1973. In several instances, powerful antipsychotic drugs have been administered to him against his will. He brought suit in the district court alleging several violations of his constitutional rights and later amended the complaint to assert a class action. The district court defined a qualified constitutional right to refuse treatment and issued a preliminary injunction directing New Jersey to establish an independent review mechanism that went beyond procedures already prescribed by the state.

Rennie is a forty year old divorced man, a former pilot and flight instructor. In 1971 he first showed symptoms of mental illness, which became more serious in 1973 when his twin brother was killed. Shortly thereafter, Rennie was admitted for the first time to Ancora, one of five hospitals for the mentally ill operated by the state of New Jersey. He was depressed and suicidal and was diagnosed as a paranoid schizophrenic. At various times during his stays, Rennie refused to accept prescribed drugs despite the hospital staff's insistence that it has a right to medicate him against his will. During his twelfth admission to Ancora, which began in August 1976 after an involuntary commitment proceeding, Rennie instituted the suit that is the subject of this appeal.

Rennie's complaint charged the defendants with violating a number of his constitutional rights.[1] By

1. The complaint alleged violations of four rights: 1) to refuse treatment in non-emergency situations; 2) to receive treatment; 3)

agreement of the parties, the litigation has focused exclusively on motions for preliminary injunctions with respect to the right to refuse treatment, leaving other issues for future determination.

After evidentiary hearings and other proceedings lasting almost a year, the district court issued its first opinion, which recognized a qualified constitutional right to refuse treatment. *Rennie v. Klein*, 462 F. Supp. 1131, 1144-45 (D.N.J. 1978). The court held that four factors determine whether treatment may be refused: (1) the physical danger posed by the patient to other patients and the staff at the institution; (2) the patient's mental capacity to decide on his course of treatment; (3) the availability of less restrictive treatments; and (4) the risk of permanent side effects from the medication. *See id.* at 1145-46.

Finding that its hearings satisfied procedural due process insofar as Rennie was concerned, the court, nevertheless, felt it "appropriate to comment on . . . the shortcomings of the state's new Bulletin 78-3 regarding psychotropic medication."[2] *Id.* at 1142. The state's fail-

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of access to counsel, and 4) to be free from physical abuse while in custody.

2 Administrative Bulletin 78-3, issued by the Division of Mental Health and Hospitals of the New Jersey Department of Human Services, details substantive and procedural standards for the administration of psychotropic medication to voluntary and involuntary patients at state hospitals.

The Bulletin is reported in full as an appendix to the district court's first opinion. *See* 462 F. Supp. at 1148-51.

The term 'psychotropic' medication refers generally to drugs used in treating psychiatric problems. One subclass of the psychotropics are the "antipsychotic" drugs, which are primarily used to treat thought disorders. Only the antipsychotics are the subject of our opinion here. Another subclass of the psychotropics are drugs such as lithium and antidepressants, which are primarily used to treat mood disorders. The latter medications, which were discussed briefly by the district court,

ures to provide for an attorney and independent psychiatrists to assist the patient in asserting his right to refuse treatment were particularly faulted. *Id.* at 1147.

Rennie later moved to amend his complaint to include class action allegations.[1] The district court granted this motion and conditionally[2] certified three subclasses. The first consists of persons who are or may be hospitalized at Ancora and asserts violations of the right to adequate treatment and safe confinement. The claims of this group have not yet been determined.

The second subclass consists of all adult patients involuntarily committed to any of the five state mental health facilities — Ancora Psychiatric Hospital, Marlboro Psychiatric Hospital, Trenton Psychiatric Hospital, Greystone Park Psychiatric Hospital, and the Glen Gardner Center for Geriatrics. The third subclass is composed of all adult patients voluntarily committed to these five institutions.[4]

Further proceedings focused on the motions by the latter two subclasses for a preliminary injunction to enforce a right to refuse treatment. Seventeen days of additional hearings were held and an opinion was issued on

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NOTE — *(Continued)*

are not considered here. *See* 462 F. Supp. at 1136-37; Rogers v. Okin, 634 F.2d 650, 653 n.1 (1st Cir. 1980), *cert. granted*, 49 U.S.L.W. 3788 (1981) (No. 80-1417).

3. The court denied Rennie's request for an injunction on his own behalf after the parties reached an agreement to use a different drug. Later, after Rennie's condition worsened, the court agreed that antipsychotic drugs should be administered. *See* 462 F. Supp. at 1152-53.

4. As originally certified, the second and third subclasses included minors as well as adults. The district court later placed voluntary and involuntary patients under the age of eighteen into separate subclasses and denied a preliminary injunction as to them because the plaintiffs "had not provided adequate proof concerning the treatment of minors and the role of parents and guardians in determining minor patients' right to refuse." 476 F. Supp. at 1298 n.2.

September 14, 1979. *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979). The district court reaffirmed its earlier conclusion that involuntarily committed patients have a substantive constitutional right to refuse medication and extended this right to voluntarily committed patients. The opinion concentrated, however, not on the substantive aspects of the right to refuse treatment, but on its procedural features.

The court ruled that the procedures promulgated in Administrative Bulletin 78-3 were insufficient to protect the substantive constitutional right it had recognized. In the district court's opinion, review of the attending psychiatrist's recommendation by the medical director was inadequate because institutional pressures would prevent him from exercising independent judgment. Additionally, the failure to provide procedures for obtaining informed consent, including a written form signed by the patients, was cited. 476 F. Supp. at 1309-10.

The court issued a preliminary injunction that requires the state hospitals to hold hearings to determine whether patients may be medicated against their will. The state must also provide a "patient advocate" to represent patients at hearings, and must retain independent psychiatrists to make the ultimate determination at those hearings. In addition, consent forms are mandated and provisions for administering drugs in an emergency are outlined. The staffs are also directed to file monthly reports on implementation of the decree. 476 F. Supp. at 1313-15.

The parties cross-appeal from the district court's order.[5] The defendants contend that the district court erred in recognizing a constitutional right to refuse treatment. In the alternative, they argue that the proce-

5. A petition for certiorari for review of the order of the district court before judment in this court was filed under U.S. Sup. Ct. Rule 18, 28 U.S.C. It was denied by the Supreme Court. 49 U.S.L.W. 3911 (No. 80-6660).

dures embodied in Administrative Bulletin 78-3 are sufficient to protect any such right.

The plaintiffs assert that the relief ordered by the district court is inadequate. They contend that independent psychiatrists retained by and responsible to the Commissioner of the Department of Human Services cannot be the neutral decisionmakers required by the due process clause. Similarly, an attack is leveled against the effectiveness of the system of patient advocates who, likewise, would be retained by and responsible to the defendant Commissioner. Finally, plaintiffs challenge the portion of the court's order that permits a doctor to medicate the patient by declaring him to be "functionally incompetent," a procedure they say can allow the circumvention of the mandatory review of all refusals of medication.

I.

We first consider the appropriate scope of review. Generally, in an appeal from the grant of a preliminary injunction we are limited to determining whether there has been an abuse of discretion, an error of law, or a clear mistake in the consideration of the proof. *Oburn v. Shapp*, 521 F.2d 142, 147 (3d Cir. 1975). This narrow standard of review springs from the realization that the proof at a hearing for a preliminary injunction is abbreviated and that the trial court, under time pressures, may not have the opportunity for the more mature consideration of issues that is expected in usual adjudications. *See United States Steel Corp. v. Fraternal Association of Steelhaulers*, 431 F.2d 1046, 1048 (3d Cir. 1970).

Our review takes into account the factors that the district court considers in ruling on an application for a preliminary injunction. The moving party

> "must demonstrate that irreparable injury will occur if relief is not granted to maintain the status quo until a final adjudication on the merits can be made

> and that there is a reasonable probability of eventual success on the merits. In addition, the court must weigh the possibility of harm to the nonmoving party as well as any other interested person and, when relevant, harm to the public."

*The Continental Group, Inc. v. Amoco Chemicals Corp*, 614 F.2d 351, 356-57 (3d Cir. 1980), *citing Delaware River Port Authority v. Transamerican Trailer Transport, Inc.*, 501 F.2d 917, 919-20 (3d Cir. 1974) (footnotes omitted). Here, the court did not expressly weigh the possibility of harm to defendants in implementing the extensive procedural mandate or to the public interest, which is clearly implicated here as well. *See e.g., Delaware River Port Authority v. Transamerican Trailer Transport, Inc.*, 501 F.2d 917, 923-24 (3d Cir. 1974).

When it is apparent that all the pertinent evidence will be presented in support of the motion for a preliminary injunction, Fed. R. Civ. P. 65(a)(2) permits the court to consolidate the hearings. Before the trial on the class action, plaintiffs' attorney had suggested a consolidation, and during the taking of testimony counsel and the court discussed this alternative on several occasions. Defense counsel approved the concept but stated he lacked the authority to consent. In the absence of clear agreement between the litigants, the court declined to consolidate.

The hearings, however, were as extensive as would be expected in the case of a permanent, rather than a preliminary, injunction. In addition, the trial court prepared a comprehensive opinion that demonstrated complete familiarity with the issues and applicable law gained after several hearings in Rennie's individual case. As is apparent, the court's injunction, although labeled as preliminary, is a sweeping and detailed order that imposes substantial, continuing obligations on the state. The decree is not simply a passive prohibition but requires positive action and substantial expenditures by

the state to carry out its provisions. The order will have a significant effect on the state budget and on the care and treatment of the institutionalized patients. In these circumstances, it is particularly appropriate to give substantial consideration to the public interest. When these factors are combined with the extensive fact finding and legal research embodied in the district court's opinions, its order requires a more searching review than is customarily provided for preliminary injunctions.

II.

There are essentially two questions presented on this appeal. First, whether compulsory medication of involuntarily committed mental patients violates a liberty interest protected by the fourteenth amendment. Second, if such an interest exists, what procedures must the state follow to protect it.[6]

We first address the liberty interest issue, which may be divided into three inquiries: (A) does state law create a liberty interest that is infringed by compulsory medication of involuntarily committed patients; (B) if not by state law, does the Constitution itself create such a liberty interest; (C) if it does, what are the substantive contours of the right to refuse treatment. We consider these matters in turn.

A.

The defendants deny the existence of a liberty interest and refer to a line of Supreme Court cases suggesting that a liberty interest protected by the due process clause must have its origin in "some right or justifiable expectation rooted in state law." *Montanye v. Haymes*, 427 U.S. 236, 242 (1976). *See also Vitek v. Jones*, 445 U.S. 480,

6. The district court refers throughout its opinion to a privacy interest as the basis of the right to refuse treatment, rather than a liberty interest. We believe that nothing of significance turns on this choice of characterizations, but feel that a right to refuse treatment is better viewed as derived from constitutionally protected liberty. We shall refer, then, to a liberty interest throughout this opinion.

488 (1980); *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1 (1979); *Meachum v. Fano*, 427 U.S. 215 (1976); *Wolff v. McDonnell*, 418 U.S. 539 (1974); *Gagnon v. Scarpelli*, 411 U.S. 778 (1973); *Morrissey v. Brewer*, 408 U.S. 471 (1972). They argue that New Jersey law does not create a right or justifiable expectation, but to the contrary, affirmatively withholds any such right.

In their characterization of New Jersey's statutory law, the defendants are probably correct. For N.J. Stat. Ann. §30:4-24.2(d)(1) (West 1981), provides in part that "voluntarily committed patients shall have the right to refuse medication." In context, the implication of the statute is that involuntarily committed patients do not have this right and a New Jersey trial court has so held. *In re B.*, 156 N.J. Super. 231, 383 A.2d 760 (1977). Research has not disclosed any New Jersey appellate opinions interpreting the statute, nor has the Supreme Court of that state had occasion to determine the application of the New Jersey constitution or the common law in this situation.[7]

State statutes or practices may give rise to a liberty interest that would not otherwise exist. Thus, the Supreme Court has held that although states are not constitutionally mandated to provide parole, *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. at 7; *Morrissey v. Brewer*, *supra*, or probation, *Gagnon v. Scarpelli*, 441 U.S. at 782, or good time credits, *Wolff v. McDonnell*, 418 U.S. at 556-57, once legislation does provide a right to these benefits, a liberty interest arises that is protected by the due process clause. By contrast, the court has

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7. There may be a lurking equal protection issue as well. If there is a constitutional right to be free from overly intrusive medication, and prima facie, involuntarily confined patients are as competent as voluntarily admitted persons, there would seem to be some question about excluding the former from the benefits of the statute. The parties have not addressed the issue, and in view of our disposition, we need not either.

held that where state statutes do not confer on an inmate the right to be incarcerated in any particular prison, but rather give prison administrators unfettered discretion to transfer inmates among different institutions, a prisoner has no liberty interest in remaining at a given location, even if a transfer is to a much more restrictive environment. *Meachum v. Fano*, 427 U.S. at 228-29; *Montanye v. Haymes*, 427 U.S. at 242-43.

A determination that a state statute itself does not create a liberty interest, however, is not the end of the inquiry. A liberty interest may flow directly from the United States Constitution itself, despite silence or contrary indication in state law. Were it otherwise, a state's statutory law would occupy a position higher than the Constitution. Thus, it is not correct to say that a liberty interest can only originate in state law. A more accurate statement is that state law can give rise to a liberty interest that would not otherwise exist.

In *Vitek v. Jones*, the Supreme Court considered whether a Nebraska prisoner had a liberty interest in not being involuntarily transferred from a prison to a state mental institution. The Court examined state law with respect to inmate transfers to mental hospitals and concluded that a liberty interest was implicated since the Nebraska statute provided for transfer only when "a prisoner 'suffers from a mental disease or defect' and 'cannot be given proper treatment in that facility.' " 445 U.S. at 483, *quoting* Nebraska Rev. Stat. §83-180(1) (1976). In the next, and, for our purposes, critical part of its analysis, the Court held that a liberty interest would be implicated even without statutory limitations on such transfers. *Id.* at 491-94. The Court accordingly held that the prisoner's transfer to a mental institution must comply with requirements of procedural due process. *Id.* at 494.

It is evident, therefore, that liberty interests may spring from the Constitution itself and can be recognized without regard to state law. Consequently, we reject the defendants' argument that because none is cre-

ated by state law, plaintiffs have no liberty interest, and next consider whether one was created by the Constitution.

B.

An individual who has not been committed to a mental institution has a right to refuse medication sought to be administered against his will. The state cannot ignore due process and simply seize a person and administer drugs to him without his consent. The case before us is one step removed, since it involves the right of an individual to refuse treatment after he has been confined to a mental institution. Such a commitment requires a proceeding in conformity with procedural due process which, under New Jersey law, requires the state to prove that "the institutionalization of the patients is required by reason of his being a danger to himself or others or property if he is not so confined." N.J. Civil Practice Rule 4:74-7(f).

An involuntary civil commitment in itself entails "a massive curtailment of liberty." *Humphrey v. Cady*, 405 U.S. 504, 509 (1972). We must determine, then, whether, as the state argues, the freedom to refuse medication normally possessed by an individual is extinguished by involuntary civil commitment, or whether the patient "retain[s] a residuum of liberty that would be infringed" by compulsory medication "without complying with minimum requirements of due process." *Vitek v. Jones*, 445 U.S. at 491.

We are not persuaded by the state's argument that involuntary commitment takes away all aspects of a person's liberty interest. In our view, the patient's liberty is diminished only to the extent necessary to allow for confinement by the state so as to prevent him from being a danger to himself or to others.

The Supreme Court has held that solitary confinement "represents a major change in the conditions of

confinement" in a prison setting, *Wolff v. McDonnell*, 418 U.S. at 571-72 n.19, and that revocation of parole, with a consequent return to prison, represents a loss to the parolee, *Morrissey v. Brewer*, 408 U.S. at 482. A fortiori, compulsory medication of a nonconsenting patient with its serious concomitant risks must be deemed a "major change in the conditions of confinement."

The extent to which the plaintiffs' liberty interest is invaded by compulsory medication appears dramatically from the record here. All the antipsychotic drugs induce a variety of disorders of the central nervous system as side effects.[8] Most serious among these is tardive dyskinesia, a potentially permanent disorder. It is "characterized by rhythmical, repetitive, involuntary movements of the tongue, face, mouth, or jaw, sometimes accompanied by other bizarre muscular activity." *Rennie v. Klein*, 462 F. Supp. at 1138. More common, but less serious than tardive dyskinesia, are akinesia and akathesia. The former can induce a state of diminished spontaneity, physical weakness and muscle fatigue. The latter is "a subjective state and refers to an inability to be still; a motor restlessness which may produce a shaking of the hands or arms or feet or an irresistable desire to keep walking or tapping the feet." *Id.* Both of these disorders usually disappear either during or shortly after the course of medication. They can sometimes be controlled by anticholinergic or antiparkinsonian medications.

8. The risk of serious side effects stemming from the administration of antipsychotic drugs is a critical factor in our determination that a liberty interest is infringed by forced medication. Although there is spirited debate in the psychiatric community over the extent and severity of serious side effects, we accept the district court's findings that such injuries occur often enough to be of deep concern. *See, e.g.*, Plotkin, *Limiting the Therapeutic Orgy: Mental Patient's Right to Refuse Treatment*, 72 Nw. U. L. Rev. 461, 474-78 (1978); Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 Harv. C.R.-C.L. L. Rev. 363, 375-82 (1980).

A variety of minor physical effects also attend the use of antipsychotics, which "include blurred vision, dry mouth and throat, constipation or diarrhea, palpitations, skin rashes, low blood pressure, faintness and fatigue. . . . These side effects tend to diminish after a few weeks," *Id.* (citations omitted). In rare cases the antipsychotic drugs have caused death.[9]

The impact of these side effects was highlighted by the testimony of several patients at the institutions. An older woman described involuntary jaw movements as a result of tardive dyskinesia so severe that she could not be fitted with dentures. As a result she is restricted to a diet of ground food. One young woman told of feeling sedated by the antipsychotic drugs to the point where she would sleep most of the day. Others testified to severe discomfort in response to the drugs. 476 F. Supp. at 1301-02.

The record convinces us that there is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs. It implicates the "right *to* be free from, and to obtain judicial relief for, unjustified intrusions on personal security." *Ingraham v. Wright*, 430 U.S. 651, 673 (1977). This intrusion rises to the level of a liberty interest warranting the protection of the due process clause of the fourteenth amendment.

In support of a substantive constitutional right to refuse medication, the plaintiffs also point to the first

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9. The district court also noted that recent research suggests that there may be a link between psychotropic drugs and suicidal depression. 462 F. Supp. at 1138. For a discussion of the possible emotional and social side effects of psychotropics, see Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull. Am. Acad. Psychiat. & L. 179 (1981); Comment, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 Wis. L. Rev. 487, 539-39.

and eighth amendments. They contend that compulsory medication deprives them of freedom of thought protected by the first amendment and constitutes cruel and unusual punishment proscribed by the eighth amendment. *See Scott v. Plante*, 532 F.2d 939, 945-47 (3d Cir. 1976). The district court rejected these alternative bases, relying instead on the right to privacy protected by the due process clause of the fourteenth amendment. 462 F. Supp. at 1143-44. We believe it is preferable to look to the right of personal security recognized in *Ingraham v. Wright*, *supra*.

We find the eighth amendment a particularly inappropriate reference point. That provision is directed to preventing excesses in the punishment of those who have been convicted of crime. Failure to provide adequate medical care is a violation of that amendment only if the deprivation is the result of "deliberate indifference" to the serious medical needs of prisoners. *Estelle v. Gamble*, 429 U.S. 97 (1976). *See also Hampton v. Holmesburg Prison Officials*, 546 F.2d 1077 (3d Cir. 1976). It is necessary to distinguish the status of prisoners who are legitimately being punished for commission of a crime from that of persons who are mentally ill or retarded through no fault of their own and are innocent of any offenses against society. These people are victims who are entitled to society's assistance and understanding. They do not merit retribution. It is a throwback to a more callous attitude of the past to equate the mentally ill or retarded person's constitutional right of personal integrity to that of criminals. We reject the eighth amendment, therefore, as the proper minimal standard for the treatment of the plaintiff classes.[10] They are entitled to more humane consideration.

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10. Although Ingraham v. Wright, 430 U.S. at 669 n.37, did not foreclose the possibility that the eighth amendment may be applicable to punishments not labeled "criminal" and mentioned mental institutions, Bell v. Wolfish, 441 U.S. 520 (1979), appears to

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C.

Having concluded that the patient has a constitutional right to be free from treatment that poses substantial risks to his well-being, we must consider the scope of that right. Like most rights, it is not absolute, but is limited by other legitimate governmental concerns and obligations. The administration of drugs generally is a recognized adjunct to the treatment of the mentally ill and indeed may be required by the state as a concomitant of its power to commit involuntarily.[11]

Under the New Jersey statutes, a person who is mentally ill may not be committed against his will unless he is a danger to himself, others, or property. *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975). He may not constitutionally be confined involuntarily if he is "dangerous to no one and can live safely in freedom." *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975). Whether a state may involuntarily commit a person solely because he may need treatment is a question the Supreme Court has not addressed, *Id.* at 573-74, and one which has evoked serious reservations by the Chief Justice. *Id.* at 589 (Burger, C.J., concurring). That issue, however, is not presented here.

The power to confine involuntarily has been justified under either the state police power or the parens patriae theory. *Coll v. Hyland*, 411 F. Supp. 905 (D.N.J. 1976) (three-judge court). The two often overlap. The powers of the state that justify deprivation of a mentally ill person's freedom from confinement are the same

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have resolved the doubt. *Wolfish* determined that the eighth amendment is an inappropriate basis for analysis of conditions in which pretrial detainees must be confined since no adjudication of guilt has been made in their case. *Id.* at 535.

11. The issue of a "right to treatment" is not presented in this case and we do not address it here. *See* Pennhurst State School and Hospital v. Halderman, ____ U.S. ____, 49 U.S.L.W. 4363, 4367 n.12 (Apr. 20, 1981).

sources of authority for administering drugs without the patient's consent. It is obvious, however, that the state's power is not without limits. A person who is committed because of mental illness may neither be detained after that condition ceases, *O'Connor v. Donaldson*, nor confined more restrictively than necessary. *See Romeo v. Youngberg*, 644 F.2d 147, 160-61, 166 (3fd Cir. 1980), *cert. granted*, 49 U.S.L.W. 3863 (1981) (No. 80-1429). Thus, without justification, the state could not shackle a mentally ill patient in a damp, unheated, inordinately small cell, when his condition is such that he could freely move about the institution.

The deprivation of liberty imposed by the state must not exceed that required by needed care or legitimate administrative concerns. What is at issue here is the administration of drugs — psychotropics — with the very real possibility of damaging results accompanying their use so that "the cure [c]ould be worse than the illness." *Rennie v. Klein*, 462 F. Supp. at 1146. To protect the liberty interest in the face of such a threat, the least intrusive infringement is required. Even a convicted prisoner retains a "residuum of liberty" that may not be infringed without due process protections. *Vitek v. Jones*, 445 U.S. at 491. And, as the Court has said, "due process requires that the nature and duration of commitment bears some reasonable relations to the purpose for which the individual is committed." *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

Much the same reasoning applies to the involuntary administration of antipsychotic drugs. The record demonstrates that these drugs can be valuable in the treatment of certain mental illnesses, relieving symptoms on a short term basis as well as for lengthy periods. Their use often makes it possible to shorten the period of confinement drastically and also makes patients more manageable and, hence, less a threat to others. Thus, both the police power and the parens patriae interests are served.

Just as the power to confine is accepted, but its nature limited, so may involuntary administration of drugs be justified only when accompanied by appropriate restrictions. The involuntarily committed patient retains a "residuum of liberty," and he correspondingly retains the right to be free from "unjustified intrusions on [his] personal security." *Ingraham v. Wright*, 430 U.S. at 673. That concept has sometimes been paired with the "least intrusive means" when objections to forced administration of drugs are raised. *See e.g., Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 49 U.S.L.W. 3788 (1981) (No. 80-1417).

Even though a person may be mentally ill, and has been properly committed involuntarily, he nonetheless is considered competent to some extent.[12] His constitutional rights to be free from confinement and personal intrusion are necessarily limited by commitment, but they are not totally extinguished. The Constitution is at least as viable behind the walls of a psychiatric hospital as in a prison. *See Vitek v. Jones*, 445 U.S. at 491-92; *Wolff v. McDonnell*, 418 U.S. at 555-56.

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12 In this opinion we address only the rights of persons involuntarily committed to state institutions where no adjudication of incompetency has been made. N.J. Stat. Ann. § 30:4-24.2(e) (West 1981), provides in part that "[n]o patient may be presumed to be incompetent because he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntary or involuntarily received."

In this respect, New Jersey's statute is like many other jurisdictions. It is simply not true that all persons involuntarily committed are always incapable of making a rational decision on treatment. For example, in this case, the district court indicated that Rennie is sometimes capable of making such a decision, but that his capacity fluctuates. *See* 462 F. Supp. at 1141. Psychiatric literature indicates that many forms of mental illness have a highly specific impact on the victims, leaving decision-making capacity and reasoning ability largely unimpaired. *See Developments in the Law — Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1214-15 (1974).

In another context, the Supreme Court said, " 'even when pursuing a legitimate interest, a State may not choose means that unnecessarily restrict constitutionally protected liberty,' *Kusper v. Pontikes*, 414 U.S. 51, 58-59 (1973), and we have required that States adopt the least drastic means to achieve their ends." *Illinois State Board of Elections v. Socialist Workers Party*, 440 U.S. 173, 185 (1979) (citations omitted). That view is consistent with the earlier case of *Shelton v. Tucker*, 364 U.S. 479 (1960):

> "In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose."

*Id.* at 488 (footnotes omitted).

The means chosen to promote the state's substantial concerns must be carefully tailored to effectuate those objectives with minimal infringement of protected interests. *See Griswold v. Connecticut*, 381 U.S. 479, 485 (1965). Although in those cases the Court wrote in the setting of legislation affecting voting and first amendment rights, it has applied the same rationale in other circumstances as well. The same philosophy applies in cases implicating a person's "right to be free from . . . unjustified intrusions on personal security," *Ingraham v. Wright*, 430 U.S. at 673, especially where, as here, physical and intellectual integrity is threatened by an unduly narrow construction of constitutional rights.[13] It appears that at least thirty-five jurisdictions

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13. The Court of Appeals for the First Circuit has adopted a similar approach. In Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 49 U.S.L.W. 3788 (1981) (No. 80-1417), the court

explicitly or implicitly acknowledge the least restrictive doctrine in their statutes as applicable to treatment or involuntarily commitment.[14]

It is true that much turns upon the medical and psychiatric facts of each case. That the constitutional standard is closely intertwined with questions of medical judgment, however, cannot defeat the patient's rights, nor require abdication of legal protection. That was made clear in *Vitek v. Jones*, 445 U.S. at 495-96, where the Court, recognizing that judges are not trained to make medical diagnoses, nevertheless found that "[t]he medical nature of the inquiry . . . does not justify dispensing with due process requirements." *See also,*

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held that before antipsychotic drugs may be administered, "reasonable alternatives . . . must be ruled out . . . Indeed, it may be possible that in most situations less restrictive means will be available." *Id.* at 656.

Congress follows the same path. Section 9501 of the Mental Health Systems Act, 42 U.S.C.A. §§9401-9503 (Supp. 1981), provides in part: "It is the sense of the Congress that each State should review and revise, if necessary, its laws," taking into account that a patient should be accorded "(1)(A) [t]he right to appropriate treatment and related services in a setting and under conditions that . . . (i) are the most supportive of such person's personal liberty; and (ii) restrict such liberty only to the extent necessary consistent with such person's treatment needs, applicable requirements of law, and applicable judicial orders."

The report of the Senate Committee on Labor and Human Resources, in commenting on the Act, quotes approvingly from the President's Commission on Mental Health: "The criterion 'least restrictive setting' refers to the objective of maintaining the greatest degrees of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services." S. Rep. No. 712, 96th Cong., 2nd Sess. 77, *reprinted in* [1980] U.S. CODE CONG. & AD. NEWS 3472, 3444.

14. *See* Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 San Diego L. Rev. 1100, 1113-15 (1977).

*Parham v. J.R.*, 442 U.S. 584, 607 (1979). Consistent with this is *In re K.K.B.*, _____ Okl. _____, 609 P.2d 747 (1980), where the court discussed the right to refuse antipsychotic drugs, saying, "in a society ruled by laws, social actions that infringe or control individual freedoms must be judged by legal standards." *Id.* at 751. "[L]iberty includes the freedom to decide about one's own health. This principle need not give way to medical judgment." *Id.* at 749.

The least intrusive means standard does not prohibit all intrusions. It merely directs attention to and requires avoidance of those which are unnecessary or whose cost benefit ratios, weighed from the patient's standpoint, are unacceptable. There must be a careful balancing of the patient's interest with those to be furthered by administering the psychotropic drug.

This is not to say that the least intrusive means requires hourly or daily judicial oversight. Obviously that would be an unworkable standard. Rather, what is reviewable is whether the choice of a course of treatment strikes a proper balance between efficacy and intrusiveness. In its search for the correct answer, a court naturally will depend upon medical and psychiatric opinion, just as it does in deciding upon the competency of a defendant to stand trial, the necessity for involuntarily commitment, and other similar medical or psychiatric issues.[15] No doubt, some cases will present sharply

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15. This same point is made in the Senate Committee Report on the Mental Health Systems Act, *supra* note 12. In discussing section 501 (1)(D) of the Act, (codified at 42 U.S.C.A. §9501 (Supp. 1981)), which requires a patient's written consent to a "mode or course of treatment," the Committee wrote that it "intend[ed] to require written patient consent only to the type, manner, and pattern of treatment. It is not intended that a separate, written consent form be required for each pill, shot or treatment administered pursuant to the agreed-upon plan." S. Rep. No. 712, 96th Cong., 2d Sess. 81, *reprinted in* [1980] U.S. CODE CONG. & AD. NEWS 3372, 3449. *See also*, Brooks, *supra* note 8.

conflicting professional viewpoints. That, however, is not a valid reason for refusing to make the inquiry.

In any event, promulgation of the standard merely serves to advise the psychiatric community that a conscious weighing of the constitutional liberty interest in any determination of proper treatment alternatives is necessary. It will not unduly hamper the standard of professional care to determine whether a different drug, or smaller dosages, or a different therapy would serve the interest of the patient as well as the state.

It must be observed that emergency conditions, for example, may require that more discretion be granted the attending physician. In the case of antipsychotic drugs, it would appear that treatment for a limited period is not as likely to have as intrusive an effect upon the patient as administration for an extended time. This, moreover emphasizes that the least intrusive standard is generally applicable to a regimen or treatment program rather than individual dosages. We emphasize that the emergency treatment provisions are not at issue in this case.

III.

Having concluded that a constitutional right to refuse treatment exists, it is necessary to consider whether the due process safeguards imposed by the district court were proper.[16]

Initially, we recognize that the decision to administer drugs depends upon a medical judgment based upon a variety of facts, such as the need for the drugs and their probable effects on the patient, including the possibility of side effects. Matters such as the likelihood of violence on the part of the patient; his previous reaction to acute psychotropic drugs, if any; the duration of pre-

16. The due process analysis is compatible with the least intrusive means approach as well as that utilized in the concurring opinions.

vious drug therapy; the prognosis for improvement or stability; alternative medications; close confinement or other alternatives; and other factors too numerous to mention here, all enter into the decisionmaking. The nature of these elements makes it plain that the determination must be made on an individual basis. Due process procedures must therefore provide an opportunity for the exercise of professional judgment in these circumstances.

From a legal standpoint, the outline of due process protections that must guide state agency proceedings are summarized in *Matthews v. Eldridge*, 424 U.S. 319 (1976). The Court listed three factors for consideration: (1) the private interest; (2) the risk of an erroneous decision through the procedures used as well as the value of the any of additional or substituted safeguards; and (3) the governmental interest, including fiscal and administrative burdens that other procedural requirements would impose. *Id.* at 335. These guidelines permit flexibility to adjust to a variety of circumstances, such as the employment of professional judgment, and do not mandate adherence to rigid, traditionally adversary proceedings. Against this background, we turn to the administrative provisions adopted by the State.

New Jersey has enacted legislation regulating treatment for the mentally ill. It includes provisions that provide for the right to "medical care and other professional services in accordance with accepted standards . . . [and] the right to participate in planning for his own treatment to the extent that his condition permits." N.J. Stat. Ann. §30:4-24.1 (West 1981). It has also enacted a mental patient "Bill of Rights," which guarantees the right "[t]o be free from unnecessary or excessive medication," the right not to have medication "used as a punishment, for the convenience of staff, [or] as a substitute for a treatment program," and the right to have adequate records of medication maintained. *Id.* at 4-24.2(d)(1). Administrative Bulletin 78-3, issued soon after this liti-

gation began, incorporates many of the provisions found in the statute and, while not conceding the right of involuntarily committed patients to refuse drugs, also defines the need for compulsory medication. For those not adjudicated incompetent, medication may be imposed involuntarily in some limited, nonemergency situations. If, without it, the patient is incapable of participating in any treatment plan that will give him a realistic opportunity to improve his condition, or if it will shorten the required commitment time, or if there is a significant possibility that the patient will harm himself or others before his condition improves, drugs may be administered. ¶ II(2)(a) & (b).

Procedurally, the Bulletin sets up a mechanism through which a decision to administer drugs against a patient's will shall be made and reviewed. At the first level, when a patient refuses to accept medication, the treating physician must explain to the patient the nature of his condition, the rationale for using the particular drug, and the risks or benefits of it as well as those of alternative treatments. If the patient still declines, the matter is discussed at a meeting of the patient's treatment team, which is composed of the treating physician and other hospital personnel, such as psychologists, social workers, and nurses who have regular contact with the patient. The patient is to be present at this meeting if his condition permits. ¶ II(B).

If, after the team meeting, the impasse remains, the medical director of the hospital or his designee must personally examine the patient and review the record. In the event the director agrees with the physician's assessment of the need for involuntary treatment, medication may then be administered. ¶ II(D). The medical director is also authorized, but not required, to retain an independent psychiatrist to evaluate the patient's need for medication. ¶ II(E)(1). Finally, the director is required to make a weekly review of the treatment program of each patient who is being drugged against his will to deter-

mine whether the compulsory treatment is still necessary. ¶ II(E)(2). In addition, the district court found that the Division of Mental Health and Hospitals had adopted a practice, not incorporated in the Bulletin, of having all cases of compulsory medication reviewed by a division director or another physician in the division's central office. *See* 476 F. Supp. at 1303.

Despite the detailed mechanisms established by Bulletin 78-3, the district court held that the procedures failed to meet due process standards. The judge found that the provisions were not being implemented by the state and that review of medication decisions by the director was not adequate. The court did not "impugn the good faith of the directors, who appear genuinely determined to reduce unnecessary reliance on drugs and to increase the involvement of patients in their own treatment decisions." 476 F. Supp. at 1310. However, "institutional pressures . . . make it impossible for anyone in the medical director's position to have sufficient independence, much less the appearance of fairness which due process required." *Id.*

For these reasons, the court expanded on the state's requirement and entered an injunction whose principal provisions:

> 1. Require the hospitals to employ consent-to-receive-medication forms, which advise patients of their right to refuse treatment, their right to have refusal reviewed before it is overridden, and describe "all known short-term and long-term side effects of the drug to be consented to," *id.* at 1313;
>
> 2. Require the Commissioner of the Department of Human Services to set up a system of "patient advocates" to represent the patients who wish to refuse treatment. These advocates may be lawyers, psychologists, social workers, registered nurses, paralegals, or other qualified laymen;

3. Require the Commission to retain independent psychiatists to make the ultimate determination by written decision on whether the patient's refusal shall be honored;

4. Prohibit hospitals from administering psychotropic medication against a patient's will, other than in an emergency, unless the independent psychiatrist so orders;

5. Direct the state to hold a hearing after five day's notice to the patient to determine whether the hospital may medicate him against his will; and

6. Order the state to provide a patient advocate to represent the patient at the hearing and to allow the patient to retain an attorney (at the patient's expense) to represent him at this hearing.

*See* 476 F. Supp. at 1313-14.

We must now determine whether the district court erred in ruling that Bulletin 78-3 was deficient and whether additional procedures were required to pass constitutional muster. Our task is not to compare the procedures of Bulletin 78-3 with those ordered by the district court, nor to determine which of the two programs is more effective in protecting a patient's right to refuse treatment, nor which is sounder as a matter of policy. Our inquiry is far narrower: do the procedures established by New Jersey satisfy due process? A federal court is not to substitute its judgment for that of state legislative and executive authorities, unless the state's response in protecting the liberty interest falls short of constitutional standards.

The first *Eldridge* factor, that of the private interest implicated in the patient's right of refusal, has already been discussed. We pass, therefore, to the next point, the risk of an erroneous decision. We are satisfied that the state's procedures, if carefully followed, pose only a minor risk of erroneous deprivation. We also are con-

vinced that this risk will not be significantly reduced by superimposing the district court's own requirements on those already required by the state.

The decision to compel medication will generally be made by members of the hospital medical staff who have had more connection with the treatment of the individual patient than an independent psychiatrist, whose experience would necessarily be limited to ad hoc situations. The weeks or months that a patient spends in these institutions should provide a more accurate and reliable basis for the staff's judgment as to whether the patient poses a danger to himself or to others and whether he is capable of making a rational treatment decision. *See Kruze v. Ward*, 558 F.2d 658, 662 (2d Cir. 1977), *cert. denied*, 434 U.S. 1018 (1978).

The adversary contest implicit in the district court's order is ill-suited to the type of medical determination that must be made. The Supreme Court made this point forcefully in *Parham v. J.R.*, where it wrote that "due process is not violated by use of informal, traditional medical investigative techniques." *Id.* at 607. The Court acknowledged

> "the fallibility of medical and psychiatric diagnosis . . . [but did] not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real."

442 U.S. at 609 (citations omitted). We find this reasoning equally applicable to the instant case. If an informal investigation by an admitting physician satisfies due process when the private interest at stake is the "massive curtailment of individual liberty" inherent in civil commitment, such informal procedures meet constitutional standards in the present context.

The final phase of our analysis of the second *Eldridge* factor examines the role of an independent decisionmaker. The district court doubted that doctors and patient advocates who are within the state mental health bureaucracy and who are responsible to the Commissioner of the Department of Human Services can be sufficiently independent to meet constitutional requirements. Although this point is arguable, it has repeatedly been rejected by the Supreme Court in analogous contexts. The Court found no due process violation in the use of decisionmakers employed by and responsible to the state bureaucracies in *Vitek v. Jones*, 445 U.S. at 496, *Parham v. J.R.*, 442 U.S. at 607, or in *Wolff v. McDonald*, 415 U.S. at 570-71 (decision in prison disciplinary proceedings made by adjustment committee composed of three prison officials).

To follow the rationale of the district court would be to void almost all intra-administrative appeals, where institutional pressures abound. We also note that the New Jersey provision for retaining an outside psychiatrist in certain circumstances tends to blunt the district court's concern that institutional pressures will prevent an independent decision. If the medical director desires some method of avoiding those influences, he has the power to call upon a disinterested authority for the final decision.

The third *Eldridge* factor is the government's interest, including the function at stake and the fiscal and administrative burdens that additional procedural requirements would impose. More than either of the first two factors discussed, this element counsels our approval of

New Jersey's regulatory system, and consequently, our rejection of the district court's response to the problem. Without question, the district court's order will impose substantial additional financial burdens on the state and even greater expenditures of staff time at the hospitals.

The Supreme Court noted in *Parham v. J.R.*, that "psychiatrists, psychologists, and other behavioral . . . experts in courtrooms and hearings are of little help to patients." 442 U.S. at 606. Moreover, the adversary proceedings contemplated by the district court are more likely to be counterproductive, adding to the tensions that may have contributed to the patient's initial commitment to the institution. The Supreme Court discussed this problem in *Parham* and remarked that the adversary atmosphere would only create stress, rather than facilitate successful long-range treatment. *Id.* at 610.

We are acutely aware of the finite state resources available for the care of the mentally ill. Diversion of these funds to finance nonessential administrative procedures, however beneficial and desirable, will not provide help for the patient's most critical needs.

The New Jersey regulations provide a series of informal consultations and reviews to determine from a medical standpoint whether administration of the drugs is necessary. To the extent that other treatment possibilities are discussed and discarded, the process also provides a reasonable exploration of the least intrusive means. *Romeo v. Youngberg, supra; Rogers v. Okin, supra. See also, Parham v. J.R.*, 442 U.S. at 606-13. The participants in the procedure are mental health professionals, rather than judges who have doffed their black robes and donned white coats. Nevertheless, the regulations and the statutes adequately focus the administrative proceedings on the facts that shape the constitutional standard and thereby protect the patients' interests at stake.

We are persuaded, therefore, that the procedures established in Bulletin 78-3 are consistent with constitutional guarantees and the district court erred in applying the appropriate legal standard. Deficiencies in implementing those procedures should be remedied by the district court — not by providing additional requirements, but by enforcing those already promulgated through the Administrative Bulletin. Any reluctance that some hospital staff members might have in meeting the standards is unlikely to continue when it becomes apparent that the court is prepared to enforce them. If, after a reasonable time, it develops that the state procedures are not working, then the court may explore other methods to guarantee the patient's constitutional rights. The record as it now stands does not demonstrate that the time for such action has arrived. We conclude, therefore, that the district court erred in engrafting its own procedures onto the requirements set out in Administrative Bulletin 78-3.

As noted earlier, it is a preliminary and not a permanent injunction that we modify. The district court retains jurisdiction over these proceedings, and may consider any future charge that the defendants refuse to recognize the constitutional right upheld here or are not complying with the procedures set forth in Administrative Bulletin 78-3 as incorporated in the modified decree. We do not address enforcement further at this point, and leave it for consideration by the district court, if appropriate. Our central concern has been with the procedures adopted by the state and their sufficiency as a matter of due process — not with whether those procedures have been breached.

IV.

Since we have determined that the provisions of Administrative Bulletin 78-3 adequately protect the liberty interest of involuntarily committed mental patients who

refuse medication, constitutional due process standards have been met.[17] In order to give interim protection to institutionalized patients we will not vacate the decree, but do modify it to incorporate the applicable terms of ¶ II of Administrative Bulletin 78-3. In proceedings after remand, the district court may wish to modify the interim decree in accordance with this opinion or to enter a permanent injunction. A form of decree is attached hereto and is designated as Appendix A.

The case will be remanded for further proceedings consistent with this opinion. Each party shall bear its own costs.

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17. This appeal has required us to review only the constitutional adequacy of New Jersey's regulations. However, on October 10, 1980, Congress passed a Mental Health Systems Act, 42 U.S.C. §§9401-9503, which includes §9501, a "Bill of Rights" for mental health patients. A comparision of §9501 with New Jersey's Administrative Bulletin 78-3 reveals that New Jersey has indeed anticipated and accommodated virtually all of the concerns expressed in the Mental Health Systems Act with the exception of the requirement for written patient consent.

We do not address any provisions of that act in this opinion, because it was not before the district court and has neither been briefed nor argued by the parties. Our decision to forgo discussion of the act will not prejudice the parties, not only because Bulletin 78-3 is consistent and compatible with the statute, but also because our holding does no more than modify the district court's preliminary injunction. As we have noted earlier, the district court retains jurisdiction and may in its discretion consider the Mental Health Systems Act as relevant to the remaining proceedings.

The modified decree which we order today includes no provisions requiring written consent forms before medication of either voluntary or involuntary patients. There is some indication in the record that the state may wish to institute such a procedure and we do no foreclose the possibility of such a requirement after further proceedings in the district court. Of course, the modified decree is not intended in any way to prevent the defendants, at their option, from implementing more expansive procedures to protect the patients' interests.

APPENDIX A

For reasons stated in the court's opinion filed this day,

It is on this _____ day of _____, 1981, hereby ORDERED of defendants Klein and Rotov:

I. Defendants shall comply with the following procedures for the adult units of the Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital, Marlboro Psychiatric Hospital, Trenton Psychiatric Hospital, and Glen Gardner Geriatric Center:

II. *The Involuntary Administration of Medication*

*Definitions*

1. A patient is considered incompetent only if he has been adjudicated incompetent by a court.

2. Medication is considered a necessary part of a patient's treatment plan when either:

   (a) The patient is incapable, without medication, of participating in any treatment plan available at the hospital that will give him a realistic opportunity of improving his condition; or

   (b) Although it is possible to devise a treatment plan that is available at the hospital and will give the patient a realistic opportunity of improving his condition; either:

      (1) a treatment plan which includes medication that would probably improve the patient's condition within a significantly shorter time period; or

      (2) there is a significant possibility that the patient will harm himself or others before improvement of his condition is realized, if medication is not administered.

A. *Emergency Administration of Medication*

The procedures described in this Bulletin are not intended to preclude the administration of

psychotropic medication to a patient in an emergency.

Therefore, if a physician certifies that it is essential to administer psychotropic medication in order to prevent the death of or serious consequences to a patient, the Chief Executive Officer is authorized to consent to the administration of the medication recommended by the physician's certification. If it is impossible to comply with this procedure without jeopardizing the life of the patient, the medication may be administered on a physician's order.

B. If a patient refuses to take the psychotropic medication that has been prescribed for him, the attending physician shall speak to the patient and *attempt to explain:* his assessment of the patient's condition; his reasons for prescribing the medication; the benefits and risks of taking the medication; and the advantages and disadvantages of alternative courses of action.

   If the patient still refuses to take the medication and the physician still believes that medication is a necessary part of the patient's treatment plan:

   (a) The physician should tell the patient that the matter will be discussed at a meeting of the patient's treatment team;

   (b) If the patient's clinical condition permits, the physician should invite the patient, to attend the meeting of the treatment team.

   (c) The physician should suggest that the patient discuss the matter with a person of his own choosing, such as a relative or friend.

C. The treatment team shall meet to discuss the physician's recommendation and the patient's response.

(1) If the patient is present, the team shall attempt to formulate a treatment plan that is acceptable to the patient and the team. The patient may agree to take medication unconditionally or under certain conditions that are acceptable to the physician.

(2) If the patient is not present, the team and the physician shall discuss the physician's recommendation and the patient's response, and shall document their respective conclusions.

D. If, after the team meeting, the physician still believes that medication is a necessary part of the patient's treatment plan and the patient still refuses to take the prescribed medication,

*Then:*

Case 1: *Patients Adjudicated Incompetent by a Court*

(1) If there is a consensus in regard to the necessity of the medication, the physician shall attempt to secure the consent of the patient's guardian.

If the patient's guardian, after reasonable notice of the proposed action and a request for consent, refuses or neglects to execute and submit a writing expressing either the grant or denial of consent,

Then, The Chief Executive Officer may consent to the administration of medication.

(2) If there is disagreement between the team and the physician in regard to medication, then the medical director (or his designee) shall conduct a personal examination of the patient and a review of the record. If the medical director (or his designee) agrees with the physician, the physician shall at-

tempt to secure the consent of the guardian.

If the patient's guardian, after reasonable notice of the proposed action and a request for consent, refuses or neglects to execute and submit a writing expressing either the grant or denial of consent,

Then, The Chief Executive Officer may consent to the administration of the medication.

Case 2: *Patients Who Have Not Been Adjudicated Incompetent by a Court*

*Part I — Voluntary Patients*

Medication may not be administered to a voluntary patient who refuses to accept it.

*Part II — Involuntary Patients*

The medical director (or his designee) must conduct a personal examination of the patient and a review of the record. If the medical director (or his designee) agrees with the necessity for medication, the medication may be administered as a part of the patient's documented individualized treatment plan.

E. *Miscellaneous*

1. *Independent Evaluations*

Whenever the medical director (or his designee) is asked to review a medication decision, the medical director shall be authorized to retain an independent psychiatric consultant to evaluate the patient's need for medication. This would be indicated particularly in cases where there is disagreement between the treating physician and the team.

If the patient is evaluated by an independent psychiatric consultant invited by the hospital and the consultant recommends a treatment

plan that does not include the administration of medication, then the medical director in the report filed in the treatment record, shall address the conclusions and recommendations of the consultant.

2. *Review*

In addition to the reviews mandated by N.J.S.A. 30:24.2(d)(1), the medical director (or his designee) shall review each week the treatment program of each involuntary patient, who is refusing to accept medication voluntarily, to determine:

(a) Whether the patient is still refusing his prescribed medications;

(b) Whether medication is still a necessary part of the patient's treatment plan; and

(c) Whether the other components of the patient's treatment plan are being implemented.

3. *Documentation*

Each step of the procedures outlined above shall be documented in the patient's chart.

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SEITZ, *Chief Judge*, with whom Judge Aldisert joins, concurring.

I agree with Judge Weis that persons who are involuntarily committed to New Jersey state mental institutions have a qualified constitutional right to refuse antipsychotic medication. As Judge Weis emphasizes, this constitutional right stems from an important liberty interest created by the due process clause of the fourteenth amendment, and not from an interest rooted in

state law. I also agree that the district court erred in finding that the administrative procedures adopted by New Jersey subsequent to the filing of the complaint in this action did not facially comport with the requirements of procedural due process. I say this because I believe Judge Weis is correct in holding that the procedures contained in Administrative Bulletin 78-3 are sufficient under the three-factor test of *Matthews v. Eldridge*, 424 U.S. 319 (1976). Furthermore, I agree that the injunction should be modified rather than vacated because of the finding of the district court that these procedures have not been fully implemented.

I write separately because I believe that the least restrictive alternative standard approved by five members of this court is not relevant in deciding the procedural and substantive due process issues presented by this appeal. In deciding whether the procedures contained in Administrative Bulletin 78-3 are sufficient under the *Matthews* test, I believe it is our duty to determine that the procedures provide reasonable assurances that there will be an opportunity for adequate input by various professionals and the patient before the patient's right to refuse medication can be overridden by the state. The least restrictive alternative standard is irrelevant to a determination of the sufficiency of Administrative Bulletin 78-3 because such a standard does not assist in deciding what *procedures* are required to protect a patient's right to refuse medication.

Furthermore, to the extent that the substantive due process rights of involuntarily committed mental patients are at issue in this case, I believe that the least restrictive alternative standard is an inappropriate standard to govern the conduct of state officials when following the procedures in Administrative Bulletin 78-3. As I noted in my concurring opinion in *Romeo v. Youngberg*, 644 F.2d 147 (3d Cir. 1980) (in banc), *cert. granted*, 49 U.S.L.W. 3863 (U.S. May 19, 1981), the

least restrictive alternative standard is improper for such purposes because "the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id.* at 178.[1] I would hold that the "substantial departure from accepted professional judgment" standard proposed in my concurring opinion in *Romeo* governs a patient's constitutional right to refuse antipsychotic medication and the state's ability to override that right.

Finally, it is not entirely clear to me how the risk of permanent side effects fits into the constitutional analysis of the other members of the court. I believe that the risk of permanent side effects, although not by itself of independent constitutional significance, is a relevant factor in determining whether an involuntarily committed mental patient has been accorded substantive due process. The risk of permanent side effects would in my view be considered along with other relevant factors in determining whether accepted professional judgment has been exercised.

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GARTH, *Circuit Judge*, concurring with whom Judges Aldisert and Judge Hunter join:

I join Part I (Scope of Review), IIA (State Law Liberty Interest), IIB (Constitutional Liberty Interest), III (Due Process Standard) and IV (Decree) of the majority opinion. I do not join in Part IIC of the majority opinion

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1. Although *Romeo* dealt with the constitutional rights of the institutionalized mentally retarded, I believe that the analysis in my concurrence rejecting the least restrictive alternative standard also applies to the constitutional rights of the institutionalized mentally ill.

which deals with "least restrictive (intrusive) treatment."

The differences between the majority opinion and this opinion center almost wholly upon two factors which were given constitutional significance by the district court in determining whether a mentally disturbed patient could refuse medication. The majority has now adopted the district court's constitutional standard which includes those two factors — "least restrictive treatment" and "risks of side effects."

In brief, the district court described a mental patient's right to refuse medication with reference to the following four factors:

> (1) does the patient constitute a physical threat to other patients and to staff at the institution;
>
> (2) does the patient have the capacity to decide on his own particular treatment;
>
> (3) do any less restrictive treatments exist; and
>
> (4) are there risks of permanent side effects from the proposed treatment.

Although I agree that involuntarily committed mental patients have a constitutional right to refuse medication under certain circumstances, and I agree with the majority that New Jersey has established appropriate procedures to protect that right, I do not agree that the existence of "less restrictive" treatments and the risk of side effects must be considered in formulating the constitutional standard. Because of my belief that concepts of least restrictive treatment and risks of side effects have no place in this constitutional analysis, a belief predicated in part on recent Supreme Court developments, I am compelled to dissent from the majority's affirmance of the district court's constitutional holding even though I concur with the majority that however a patient's constitutional rights are measured, New Jer-

sey's regulations[2] are more than adequate to vindicate those rights.

I.

As I have noted above, the district court analyzed the right of a patient to refuse medication with reference to four constitutional factors.

The majority apparently agrees with this formulation. However, in affirming the district court's constitutional analysis, the majority emphasizes the district court's third factor (availability of less restrictive treatment) and virtually ignores the district court's fourth factor (risk of side effects). As I have stated, in my opinion, these two factors have no place in a *constitutional* determination of whether medication may be refused. In order to explain my position which restricts constitutional considerations to (1) the patient's danger to others and to himself, and (2) his mental capacity, a brief review of the relevant legal precepts is in order.

In determining the scope of the right to refuse treatment, I begin with an accepted principle of due process: the state may not infringe a liberty interest without demonstrating at least the existence of a rational relationship between the need to intrude on such a protected interest and a legitimate state purpose. The Supreme Court has itself endorsed this principle in the context of involuntary commitment of the mentally ill. The Court has noted that involuntary civil commitment entails "a massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), and has held that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Jackson v. Indiana*,

1. New Jersey Division of Mental Health and Hospitals Administrative Bulletin 78-3 appears as the Appendix to the district court's opinion in Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978) at 1148-1151.

406 U.S. 715, 738 (1972). Thus to this extent, I agree with the majority that involuntary medication of the mentally ill implicates a liberty interest within the meaning of the due process clause. It is important then, to discern the legitimate state interests underlying civil commitment of the mentally ill, and determine under what circumstances involuntary medication may be said to be rationally related to these legitimate state interests.

The state is generally said to have three interests in the involuntary commitment of the mentally ill: prevention of harm to other persons or to property, prevention of harm to the individual who is committed, and treatment or care of an individual in need of it. *E.g., Jackson v. Indiana*, 406 U.S. 715, 737 (1972); *Donaldson v. O'Connor*, 493 F.2d 507, 520 (5th Cir. 1974), *vacated and remanded on other grounds*, 422 U.S. 563 (1975). These three state interests reflect the exercise of two distinct state powers: the police power to protect the health and safety of the community, and the *parens patriae* power to act on behalf of an individual who does not have the mental capacity to act in his own best interests.[2] The prevention of harm to other persons or to property, the subject of the first category of state interests listed above, is a legitimate exercise of the police power.[3] Skipping to the third state interest — treatment or care of the committed individual is an exercise of the *parens patriae* power. The second category of state interests, preventing harm to the individual who is committed, draws on elements of both the police and *parens patriae* powers. *Donaldson v. O'Connor*, 493 F.2d 507,

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2. *See* Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980) (*en banc*) *cert. granted*, 49 U.S.L.W. 3863 (May 18, 1981) (80-1429).

3. "When civil commitment is used to vindicate a societal interest rather than to further the interest of the mentally ill individual, it constitutes an exercise of the police power." *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1222 (1974).

520-21 (5th Cir. 1974), *vacated and remanded on others grounds*, 422 U.S. 563 (1975).

While these two state powers — the police power and the *parens patriae* power — may provide a basis for the involuntary administration of anti-psychotic drugs to the mentally ill under certain circumstances, as the majority holds and as I agree, they nevertheless do not confer unlimited authority on the state to administer medication against a patient's will. Where the state, in seeking to further its legitimate interests, utilizes, as it does here, means that violate bodily integrity and that constitute a massive imposition on the individual, the courts are charged with limiting the exercise of state authority to only those instances which bear a reasonable relationship to the state purposes to be served.

Thus, as I see it, the state under its police power may administer drugs against a patient's will, but *only* when such an action is necessary to prevent the patient from endangering himself or others. And the state may administer drugs under its *parens patriae* power, when the best interests of the patient so require, but *only* when the patient himself does not have the mental capacity to decide on the course of treatment to pursue.[4]

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4. As the majority points out, typescript at 17, note 12, it cannot be assumed that an individual does not have the capacity to make a rational decision on a course of treatment simply because he has been involuntarily committed to a state mental institution.

One commentator writes:

> If every mental illness automatically rendered the affected individual incapable of rational decisionmaking regarding the advisability of hospitalization, there would be no due process objection to *parens patriae* commitments based solely on the presence of mental illness. However, psychiatric literature indicates that many forms of mental illness have a highly specific impact on their victims, leaving decisionmaking capacity and reasoning ability otherwise largely unimpaired. Moreover, in numerous areas of the law, lack of capacity to undertake the relevant function rather than the mere presence of a mental ill-

*Winters v. Miller*, 446 F.2d 65, 68-71 (2d Cir.) (until determined to be incompetent, mentally ill individual retains the power to refuse treatment), *cert. denied*, 404 U.S. 985 (1971); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1094 (E.D. Wis. 1972) (three judge court) (mentally ill individual should be permitted to make decision on whether to accept hospitalization "unless the state can prove that the person is unable to make a decision about hospitalization because of the nature of his illness"), *vacated and remanded on other grounds*, 414 U.S. 473 (1974); *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1212 (1974) (improper to extend *parens patriae* power to "those who are capable of making their own treatment decisions").[5] Forced administration of drugs outside these contexts cannot be regarded as rationally related to the legitimate state interests underlying civil commitment of the mentally ill, and must be deemed a violation of due process.

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NOTE — *(Continued)*

> ness is required to justify an exercise of the *parens patriae* power.
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> *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1214-15 (1974) (footnotes omitted).

5. The limitation on *parens patriae* commitments suggested by *Lessard* and *Winters* appears to be required by the due process clause. Since the state interest in acting as *parens patriae* is premised on the need for the state to act to protect the well-being of its citizens when they cannot care for themselves, the imposition of involuntary commitment would seem necessary to vindicate that interest only when an individual is incapable of making his own evaluation of his need for psychiatric treatment. By contrast, compulsory hospitalization of persons with the mental capacity to determine the desirability of obtaining care in accordance with their personal values would

> interfere with individual autonomy and physical liberty without any assurance that the state, as a substitute decisionmaker, would better ascertain the best interest of the individual.
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> *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1213-14 (1974) (footnotes omitted).

I recognize that the defendants here argue for a broader authority in the state to compel medication. They refer to the state interest in providing treatment to those in need of it who have been involuntarily committed. They argue, and to this extent I agree with them, that the state has a legitimate interest in treating the sick. If an individual is in need of treatment, as Rennie and the members of his class unquestionably are, the state contends that the compulsory treatment of such a person is rationally related to a legitimate state objective. Thus, under the state's view, the *need* for treatment *alone* provides the necessary authority permitting treatment against a patient's will.

I have little difficulty in rejecting this position. There can be no dispute that an individual who has not been committed to a mental institution, has a broad due process right not to be medicated against his will. If we were to accept the defendants' view here, this due process protection would largely evaporate, for if the need for treatment *alone* would provide a warrant for compulsory treatment of a committed person, it would similarly provide a warrant for treating those who have not been committed, but who nonetheless require treatment. Recognizing such authority in the state is plainly inconsistent with the kernel of personal autonomy protected by due process. Thus, it cannot be the mere need for treatment that, without more, empowers the state to provide it in the face of an individual's refusal, but that need must be linked to the state's power to protect the patient or the community from danger, or to the state's power to act on behalf of an individual who does not have the capacity to act in his own behalf. For the purposes of this discussion, the difference between a committed and an uncommitted individual is that the committed individual is more likely to present a danger to himself or society, or to be unable to act in his own best interests.

Thus, to summarize my position: the state may administer anti-psychotic medication in the face of a patient's refusal to accept medication *only* when the state demonstrates either that the medication is necessary to prevent the patient from posing a danger to himself or to others, or that the patient does not have the mental capacity to make a rational decision with respect to medication.[6] Under my analysis, therefore, no other factors qualifying, modifying, or embellishing these two tests are relevant as constitutional measures. Because the district court included two additional considerations which I believe are irrelevant and because the majority opinion affirmed that analysis, I turn next to a consideration of "least restrictive treatment" and the risk of side effects as constitutional measurements of a patient's right to refuse treatment.

II.

The district court held that the patient's right to refuse treatment had to take into account "whether any less restrictive treatments exist," and "the risk of permanent side effects from the proposed treatment." *Rennie v. Klein*, 462 F. Supp. at 1152. The majority opinion expands upon and qualifies the district court's least restrictive standard, construing it as generally limited to "course of treatment" decisions as distinct from discrete instances of medication. (maj. op. typescript at 20)

6. Other than in the respect that Massachusetts legislative enactments differ from those of New Jersey, I do not read the recent First Circuit Court of Appeals opinion in Rogers v. Okin, 634 F.2d 650, (1st cir. 1980) *cert. granted*, 49 U.S.L.W. 3788 (1981), as varying in any substantial or material manner from my analysis here. Nor do I read the *Rogers* discussion of a least restrictive standard as a constitutional imperative. Rather, that discussion, in the context in which it appears, seems to me in its nature to be more akin to the non-constitutional administrative provisions which appear in New Jersey Administrative Bulletin 78-3.

While not excluding emergency conditions, the majority would grant "more discretion" to an attending physician in such situations in choosing the "least restrictive treatment." *Id.* As I indicate below, neither the formulation now announced by the majority nor the formulation announced by the district court is relevant in a constitutional context.

I am satisfied that my analysis to this point compels the conclusion that an involuntarily committed mental patient has a constitutional right to refuse medication, subject only to the two overriding state interests that I have described. I am equally satisfied that I have provided a complete definition of that right, and that there are no further constitutional limitations on the state's power to compel medication beyond those that I have set forth. Thus, it is in this posture that I note my disagreement with the last two factors found in the district court's four-factor analysis and adopted by the majority here.

A.

It must be kept in mind that despite the disclaimer found in the majority opinion, (maj. op. typescript at 19), we are faced with reviewing here day-to-day, even hour-to-hour decisions by hospital staff respecting the administration of medication on a continuing basis. The record developed in the district court demonstrates that the reactions to such treatments are highly individualized and vary markedly from patient to patient. It would not only be impractical for a court to attempt to review these treatment decisions under a "least restrictive alternative" approach, but it seems inevitable that such review would interfere dramatically with the administration of needed medication and essential therapy. Moreover, the imposition of such a standard would, as a practical matter, require each district court judge to ex-

change his robe for a medical gown.[7] Each judge would of necessity be obliged to assume a supervisory role in the medical discipline, becoming both a super-diagnostician and super-physician for each institutionalized patient. In this very case, for example, the district court was repeatedly called upon to hold hearings and to rule in a medical context on various aspects of Rennie's day to day treatment.

In a somewhat analogous context and as the forerunner of a least restrictive doctrine as a constitutional measure these concerns were discussed in our recent *en banc* decision in *Romeo v. Youngberg*, 644 F.2d 147 (3d Cir. 1980) *cert. granted*, 49 ULSW 3868 (1981). That case dealt with the constitutional standards applicable to the care of mentally retarded patients in a state institution. Romeo, the patient, sought the right to be free from bodily restraint, a right to personal security and protection from attacks by other inmates, and a right to adequate treatment. However, neither the issues presented in *Romeo*, nor the claims made by the patient Romeo, nor any aspect of the *Romeo* record involved the subject with which we are concerned here, i.e., the refusal of an involuntarily committed mentally ill patient to accept anti-psychotic medication. Nor did the *Romeo* record involve the problems and characteristics of the mentally *ill* which are critically different from those of the mentally *retarded* patients.[8]

In its discussion, the majority opinion in *Romeo*, did not hold, as it could not in light of the record on which it was predicated, that "[n]onreversible physical oper-

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7. Even the majority opinion recognizes that the participants in the procedure adopted by New Jersey to vindicate the patient's due process rights must be "mental health professionals rather than judges who have doffed their black robes and donned white coats." (msa) op. typescript at 27)

8. Romeo v. Youngberg, *supra*, at p. 154 n.1. *Cf.* Kremens v. Bartley, 431 U.S. 119, 135-36 (1977).

ations" or "the administration of powerful antipsychotic drugs" constitute constitutional violations. Rather it merely stated, that such procedures "may well constitute fundamental liberty violations," and that a "least restrictive analysis," may, therefore, be indicated. The majority opinion, there, explained "[w]here the issue turns on which of two or more major treatment *approaches* is to be adopted, a 'least intrusive' analysis may well be appropriate."[9] Following this explanation, the majority opinion in *Romeo* concluded with the following proposed jury instruction which appears in the *Romeo* Appendix as III.C., *supra*, p. 173.

> C. If you find that a selection of a mode of treatment subjected the plaintiff to significant deprivations of liberty, then you must go on and determine whether that decision provided for the least intrusive treatment available under the circumstances. If the defendants considered other alternatives and ascertained that the program adopted was the least intrusive available, then you should find the defendants not liable.

Although *Romeo*, as I have pointed out, cannot govern the least restrictive standard adopted by the majority in this case,[10] I recognize that the majority opinion has drawn heavily on *Romeo* in order to fashion the contours

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9. *Id.* at 166.

10. The *Romeo* discussion, as it pertains to anti-psychotic drugs and surgery has been characterized as "bald dictum." *Id.* at 186 (Garth, J., concurring).

Chief Judge Seitz, in his concurring opinion in *Romeo* stated:

> I also emphasize that, as the majority appears to concede, this appeal does not present claims involving nonreversible surgery or the administration of antipsychotic drugs. Therefore, in my view, the majority opinion would not be controlling if such claims were asserted in other litigation. *Id.* at 173 n.1 (Seitz, C.J., concurring).

Romeo v. Youngberg, 644 F.2d 147, 178 (3d Cir. 1980).

of *Rennie's* least restrictive constitutional standard. The majority here, however, contrary to the district court's formulation, which it affirms, rejects the least restrictive concept as it pertains to "individual dosages." Rather the majority maintains that the Constitution requires that any *medical treatment program* prescribed (as contrasted with the administration of individual dosages of medication that the program calls for) must be the "least restrictive." I cannot agree for at least three reasons.

First, because we are bound here by the record in this case, I do not feel free, as apparently the majority does, to hypothesize under what circumstances, and on what differing records, a choice between treatment modes might arise, and once having arisen, might be regarded as sufficient to trigger the formulation of a constitutional standard. That exercise, I suggest, should be deferred until such an issue is properly presented on an appropriate record.

Here, on an extensive record which took over thirty days of district court hearings to develop, there is no evidence of a choice between major courses of treatment, nor is there any evidence of any major course of treatment that was considered as an alternative to the psychotropic drug treatment by which Rennie was medicated. Moreover, it not only appears that other modes of treatment were inappropriate, but the district court flatly held that, in the case of an individual such as Rennie, the course of drug treatment which he received was both indicated and required. 462 F. Supp. at 1140.[11]

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11. Even if the *Rennie* record revealed that two or more modes of treatment were considered appropriate for Rennie, which it does not, I cannot help but observe that in the instant context, even that predicate appears to be faulty because it would require that acceptable, although differing, medical judgments must be measured by a constitutional standard.

As Chief Judge Seitz stated in his concurring opinion in *Romeo*, *supra*, an opinion in which I joined:

The district court found that Rennie was "acutely psychotic at times," and accepted Dr. Stinett's testimony that Rennie's symptoms warranted both anti-psychotic medication and lithium. The anti-psychotic drug was deemed necessary to curb Rennie's perceived delusions and to control his destructive behavior. 462 F.Supp. at 1140. The court was satisfied that any distinction between schizophrenia and manic depression[12] was academic in this case, as either condition warranted the administration of anti-psychotic medication and lithium, *id.*, and drugs were most useful in diffusing schizophrenic thought patterns during acute psychotic episodes. 476 F. Supp. at 1298. It also found "that the benefits and detrimental side effects of all psychotropic drugs are similar." 462 F. Supp. 1135. It found "no evidence supporting the superiority of any one of these drugs" over any other. *Id.* at 1136-37.

The district court found further that such "drugs tend to shorten hospital stays and allow patients to function in the community" and referred to testimony "that the failure to treat an acutely psychotic patient with

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In my view, the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made.

*Id.* at 178.

For an interesting discussion of the least restrictive doctrine as applied to the mentally afflicted, see *Hoffman & Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 San Diego L.Rev. 1100 (1977). Among other admonitions expressed, the authors warn against the danger of elevating legal precepts above effective medical therapy. *Id.* at 1103-1105.

12 Manic depression is basically a mood disorder while schizophrenia is primarily a thought disorder characterized by delusions, hallucinations, and faulty logic. Manic depressives, however, may also display thought disorders at the manic end of the mood patterns whereas schizophrenia is characterized by sustained rather than episodic periods of thought disorder. 462 F.2d at 1139-1140.

drugs would [constitute] malpractice." *Id.* at 1137. In this connection it found that "[m]ore studies exist demonstrating the efficacy of the psychotropic drugs in the treatment of schizophrenia than for any other mode of treatment" and that such drugs may be necessary for a patient "to effectively participate and benefit from other types of therapy, including individual or group psychotherapy and occupational therapy." *Id.* The district court, therefore, found that "psychotropic drugs are widely accepted in present psychiatric practice" and "are the treatment of choice for schizophrenics." *Id.* These findings are not challenged as clearly erroneous. *Krasnow v. Dinan*, 465 F.2d 1298 (3d Cir. 1972).

Thus, the record and the district court's findings demonstrate beyond question that *in this case* the only mode of treatment appropriate and considered for Rennie was medication with anti-psychotic drugs. The ensuing discussions in the district court's opinions[13] consequently dealt *not* with different courses of treatment, but rather with the manner and the extent by which Rennie would be medicated with such drugs. It was in this setting — a setting involving *individual dosages* — that the district court formulated its "least restrictive" constitutional analysis — an analysis which I reject. While the majority opinion appears to interpret the district court's least restrictive standard in terms of courses of treatment, it nevertheless apparently still adheres to the district court's view that "different drug[s]" or "smaller dosages" or "different therap[ies]" are to be considered in determining the least restrictive standard of professional care. (maj. op. typescript at 20.)[14]

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13. Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978) and Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979).

14. If despite its apparent disclaimer, the standard which the majority now announces does include constitutional and thus judicial oversight over least restrictive dosages and treatments, many of which are administered as often as four or more times a day, even

However, regardless of how the majority interprets the meaning of its "least restrictive standard" in my opinion, any attempt to construct a "least restrictive" constitutional standard in an area where medical judgment should control is unsound, unworkable and unwarranted. The many subjective determinations that form the matrix of a medical judgment are best left to the members of the medical profession. Such determinations ought not to involve the judiciary in an assessment, even if one can be made, as to whether a particular mode of treatment or a particular discrete treatment, is more or less intrusive than another.

Second, the majority has evolved its "least restrictive" treatment standard from cases far removed from the context of treatment involving the mentally ill. In 1960, the Supreme Court decided *Shelton v. Tucker*, 364 U.S. 479 (1960) and introduced the concept of "less drastic means" into our jurisprudential vocabulary. In *Shelton*, a first amendment case, in explaining why an Arkansas statute was unconstitutional, the court focused on the availability of "less drastic means" in order to attain legitimate governmental objectives. The Arkansas statute required public school teachers to annually list all of their organizational affiliations for the preceding five years. The Supreme Court, while acknowledg-

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*Romeo* from which the majority's present standard was derived would find such a standard unsuitable. *Romeo* itself stated:

> . . . the application of a constitutional standard of "least intrusive alternative" on continuing treatment programs, which often involve qualitative medical determinations subject to daily, possibly hourly changes, would prove unworkable. The judiciary is not in a particularly advantageous position to determine which of two medications is less intrusive, nor especially competent in assessing present therapeutic benefits versus long-term consequences and side effects for each administration of a drug.

*Romeo*, *supra*, at 166-67.

ing that in some respects, the governmental purposes behind Arkansas' requirement might serve legitimate and substantial objectives, nevertheless held that such purposes cannot be pursued by means that stifle "fundamental personal liberties when the end can be more narrowly achieved." *Id.* at 488. The court, in striking down the statute, therefore required as common sense would dictate, that "the breadth of [a] legislative abridgement must be viewed in the light of *less drastic means* for achieving the same basic purpose". *Id.* As Chief Judge Seitz observed:

> Since its first exposition of the less drastic means doctrine, the Supreme Court has been rather cautious in using the doctrine because some less drastic alternative almost always exists. If used without caution, the doctrine could invalidate almost any state action. *See generally Illinois State Board of Elections v. Socialist Workers Party*, 440 U.S. 173, 188-89, 99 S.Ct. 983, 992-93, 59 L.ed.2d 230 (1979) (Blackmun, J., concurring); Note, *Less Drastic Means and the First Amendment*, 78 Yale L.J. 464, 472 (1969).

*Romeo v. Youngberg*, *supra*, at 180 (Seitz, C.J., concurring)

Moreover, the cases giving rise to the least restrictive doctrine, some of which are relied upon by the majority in extending this doctrine to *Rennie*, involve only a single legislative enactment or a discrete state action as contrasted with the continuing judicial supervision required in a context such as the present one. *See, e.g., Illinois State Board of Elections v. Socialist Workers Party*, 440 U.S. 173, 185 (1979) (statute prescribing number of signatures required for listing on electoral ballot); *Hunt v. Washington State Apple Advertising Commission*, 432 U.S. 333, 353 (1977) (statute regulating labeling of apples shipped into state); *Pike v. Bruce Church, Inc.*,

397 U.S. 137, 142 (1970) (administrative order regulating shipment of cantaloupes out of state); *Aptheker v. Secretary of State*, 378 U.S. 500, 508 (1964) (statute prohibiting issuance of passports to members of Communist organizations); *Shelton v. Tucker*, 364 U.S. 479, 488 (1960) (statute requiring teachers to disclose organizations to which they belong or which they support); *Dean Milk Co. v. City of Madison*, 340 U.S. 349, 354 (1951) (ordinance requiring pasteurization of milk at approved plants within five miles of center of city).

Application of the least restrictive principle in those cases did not require continuing judicial scrutiny, nor did it require judicial intrusion and a continuing judicial presence in another professional discipline. All are inevitable in the present context. I therefore do not believe that the constitutional right to refuse treatment which both the majority and I recognize, albeit on different bases, can either be enlarged or diminished in scope depending upon the course of treatment adopted or the frequency of administration, dosage, or kind of medication prescribed.

Third, the continued vitality of Romeo's "least intrusive choice of treatment" standard is questionable in any event.[15] *Halderman v. Pennhurst*, 612 F.2d 84 (3d Cir.

15. As the majority opinion recites, typescript at 3-6, Rennie's complaint was filed in 1976. At the district court level, three published opinions have been filed. The first was filed in response to Rennie's motion for a preliminary injunction. Rennie v. Klein, 463 F. Supp. 1131 (D.N.J. 1978). The second, reported with the first, responded to a renewed motion for a preliminary injunction. Rennie v. Klein, 462 F. Supp. 1151 (D.N.J. 1978). The third responded to the motion for a preliminary injunction on behalf of a certified class. Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979). A panel of this court first heard the present appeal on April 22, 1980. The panel's opinion was circulated among the members of the court but its filing was withheld pending the filing of the court's *en banc* opinion in Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980). *See* Romeo v. Youngberg, 644 F.2d 147, 186 (3d Cir. 1980) (Garth, J., concurring).

1979) (*en banc*) *rev'd and remanded*, 49 U.S.L.W. 4363, (April 20, 1981), which addressed only the rights of the mentally retarded, and not the rights of the mentally diseased, as we do here, held in a statutory, and not a constitutional, context that the Developmentally Disabled

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NOTE — *(Continued)*

Prior to that date, this court had reviewed, on appeal, Halderman v. Pennhurst, 612 F.2d 84 (3d Cir. 1979) *(en banc) rev'd and remanded* 49 U.S.L.W. 4363 (April 20, 1981). We held that the Developmentally Disabled Assistance And Bill of Rights Act, 42 U.S.C. §§6001-6081 (1976), required that the mentally retarded be habilitated in the least restrictive *environment*. Chief Judge Seitz, in his concurring opinion in Romeo v. Youngberg, 644 F.2d 147, 180 (3d Cir. 1980) succinctly characterized the distinction between environment and treatment:

> In short, even if least restrictive alternative analysis provides an appropriate framework for answering the question of *where* to place the mentally retarded, it is simply too rigid a tool once we leave that question and focus on *conditions* of care and habilitation within a particular institution. (emphasis supplied)

As noted in text, the Supreme Court reversed *Halderman* calling into grave question the reliance which the *Halderman* majority had placed on a least restrictive analysis even where it only involved the long term habilitation needs of the mentally retarded.

The First Circuit's opinion in Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980) *cert. granted*, 49 U.S.L.W. 3788 (April 20, 1981), involved essentially the same issue as this case, i.e., may a mentally diseased involuntarily committed patient, as distinct from a mentally retarded patient, refuse medication. The discussion in *Rogers*, which held that a patient could constitutionally refuse medication under certain circumstances briefly adverted to the relevance of "less restrictive alternatives." Rogers v. Okin, *supra*. The Supreme Court evidencing, in my opinion, its interest in the relevance of "least restrictive alternatives" in the care, treatment, and housing of both mentally retarded and mentally diseased patients, granted certiorari in both Rogers v. Okin *supra*, and Romeo v. Youngberg, *supra*. It was against this background that this court considered *en banc* the present case, Rennie v. Klein, and the majority opinion adopted as part of its constitutional standard a least restrictive treatment test.

Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et. seq.*, required habilitation of the mentally retarded in the least restrictive environment.

Our decision in *Halderman* was reversed by the Supreme Court shortly before *Rennie* was argued. Justice Rehnquist, writing for the Supreme Court, analyzed the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.*, and indicated that in his view it was questionable whether the least restrictive concept was appropriate in that setting. *Pennhurst State School and Hospital v. Halderman*, 49 U.S.L.W. 4363, 4367 n.12 (April 20, 1981).

Shortly thereafter the Supreme Court granted certiorari to the First Circuit to consider that Circuit's analogue to *Rennie*, *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980) *cert. granted* 49 U.S.L.W. 3788 (1981). *Rogers* also refers to the least restrictive standard and the Supreme Court then granted certiorari to consider *Romeo v. Youngberg*, *supra*, itself, the very case which gives rise to the least restrictive standard adopted by the majority here. Logic would indicate that the likelihood of the survival of "least restrictive" as a constitutional standard is slight indeed. Thus, it seems wrong for the majority, in the face of these case developments, to factor into an otherwise appropriate constitutional standard, a doctrine which is already inappropriate and suspect in this area and which has been torn out of its original first amendment context.

In my opinion, therefore, whatever vitality a "least restrictive alternative" doctrine may have in other contexts, and we address none such other here, there is no place for such an doctrine in a constitutional analysis of a patient's right to refuse medication under these circumstances.[16]

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16. I note Justice Blackmun's uneasiness with the "least restrictive" test:

> I add these comments to record purposefully, and perhaps

B.

I also differ with the district court in its inclusion of the fourth factor, "the risk of permanent side effects from the proposed treatment," as a consideration in defining the circumstances under which the state may compel treatment. As I noted earlier the majority opinion does not even address this factor. I believe that the district court's analysis which has apparently been affirmed by the majority opinion but without discussion, confuses the contexts in which consideration of this factor is appropriate.

The majority opinion properly discussed the risk of side effects in determining the existence of a patient's liberty interest in refusing treatment. *See* maj. op. typescript at 12-13. But a holding that the risk of side effects plays a role in determining whether a liberty interest is implicated does not go the whole way. It does not answer still another critical question: under what circumstances may treatment be refused by the patient or, conversely, compelled by the state? I have answered that question by stating that in my opinion the state may compel medication when it demonstrates either that the patient poses a danger to himself or to others, or that the

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NOTE — *(Continued)*

somewhat belatedly, my unrelieved discomfort with what seems to be a continuing tendency in this Court to use as tests such easy phrases as "compelling [state] interest" and "least drastic [or restrictive] means." . . . And, for me, "least drastic means" is a slippery slope and also the signal of the result the Court has chosen to reach. A judge would be unimaginative indeed if he could not come up with something a little less "drastic" or a little less "restrictive" in almost any situation, and thereby enable himself to vote to strike legislation down. This is reminiscent of the Court's indulgence, a few decades ago, in substantive due process in the economic area as a means of nullification.

Illinois State Board of Elections v. Socialist Workers Party, 440 U.S. 173, 188-89 (1979) (Blackmun, J., concurring).

patient does not have the mental capacity to rationally refuse treatment.

The district court, however, rather than employ its fourth factor solely in the determination of the existence of a liberty interest, would *balance* the risk of permanent side effects against the danger that the patient presented to himself or others, and against the patient's incapacity to rationally determine his course of treatment. Such an analysis would allow the patient to refuse medication entailing a risk of side effects even when the patient posed a risk of harm to himself or to others.

Just as I reject the district court's balancing formula and the majority opinion's adherence to a least restrictive standard, so too it seems plain to me that the state's power to administer medication posing a risk of serious permanent side effects is indeed *limited*, but *not* by the patient's right to refuse treatment. It is, rather, limited by the *standard of care* with which the state is charged. The state, under my analysis, has power to treat a person against his will once it demonstrates that the treatment compelled is essential for the safety of the individual or the community. Alternatively, the state has power to compel medication when it appears that the patient does not have the capacity to decide for himself on the appropriate course of treatment. Once the state has satisfactorily demonstrated that it may compel treatment, it may treat that person even if the only medication or treatment available poses a risk of permanent side effects. *How much* risk the state may impose on an involuntary patient must be determined with reference to the applicable standard of care. The state cannot provide medical treatment that entails an unacceptably high risk of serious side effects in light of the patient benefits to be gained and the disorders to be remedied. Such a course of treatment would constitute medical malpractice. Even more so, the state cannot compel treatment where its conduct would transgress the more stringent stand-

ard (for a plaintiff to meet) by which constitutional torts are measured.[17] Thus, I recognize that the risk of permanent side effects limits state authority to administer medication. But these risks do not *independently* strengthen the patient's due process right to refuse medication, and do not *independently* figure in the calculus of when the state may compel medication over a patient's refusal. It is this distinction that is critical for the purposes considered here, and in failing to recognize this distinction, I would hold the district court's analysis and consequently the majority opinion's affirmance of that analysis to be flawed.

III.

I conclude, then, that the protection of liberty embodied in the due process clause of the Fourteenth Amendment includes a right to refuse administration of anti-psychotic drugs. The state may compel such medication in the face of a patient's refusal to accept it only by demonstrating either that the medication is necessary to prevent a danger to the patient or to others in the com-

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17. I deliberately do not define this latter standard, as it is not necessary to the determination here. My only purpose in referring to a constitutional standard of care is to make clear that the risk of permanent side effects is a question restricted to a standard of care, not a factor to be considered in the right to refuse treatment itself. Nevertheless, I observe that whatever the constitutional standard may be, it does not in this context include any "right" to the least restrictive form of treatment, for the reasons discussed in text *supra*.

In this connection, *see also* Romeo v. Youngberg, *supra*, p. 173-81. (Seitz, C.J., concurring), which proposes as a constitutional standard, with which I agree:

> the defendants are liable if their conduct was such a substantial departure from accepted professional judgment, practice, or standards in the care and treatment of this plaintiff as to demonstrate that the defendants did not base their conduct on a professional judgment.

*Id.* at p. 178.

munity, or that the patient does not have the mental capacity to determine for himself his course of treatment. Because the majority opinion has added to this constitutional measurement inappropriate and irrelevant considerations of "least restrictive treatment" and risks of side effects, neither of which I regard as constitutional imperatives, I respectfully disagree.

To the extent, however, that the majority opinion holds that New Jersey's procedures protect the liberty interest of involuntarily committed mentally ill patients to refuse medication, I join the majority and thus concur in that holding. I do so because in considering an appeal from the entry of a preliminary injunction, our scope of review is limited to "determining whether there has been an abuse of discretion, *an error of law* or a clear mistake in the consideration of the proof." *Oburn v. Shapp*, 521 F.2d 142, 147 (3d Cir. 1975). (emphasis supplied) It is obvious to me from the discussion of Administrative Bulletin 78-3 in the majority opinion, that the district court's injunction must be vacated on the ground that the district court erred as a matter of law in concluding that the procedures established by New Jersey did not satisfy the requirements of due process.

GIBBONS, *Circuit Judge*, dissenting:

I join in Part II of the opinion of the court which sets forth the legal standards applicable by virtue of the fourteenth amendment to the involuntary imposition of medical treatments by persons acting under color of state law. I dissent, however, from the judgment of the court insofar as it modifies the preliminary injunction which was entered in the trial court, because the findings supporting that injunction were not clearly erroneous and the scope of pendente lite relief which was ordered was well within the range of permissible district

court discretion. Part III of the opinion of the court does not satisfactorily explain why, in reviewing that preliminary injunction, we are free in this case to disregard those findings or to substitute our discretion for that of the trial judge.

The majority opinion concludes that Administrative Bulletin 78-3 sets forth procedures which, if followed, satisfy fourteenth amendment due process standards for the protection of the liberty interest it recognizes. In the abstract that may be so. The district court was not, however, dealing with abstractions. It was presented with a record of ongoing substantive violations of that liberty interest by those state officials having custody of the unfortunate class members whom Rennie represents. The record also shows that Bulletin 78-3 was adopted only after this lawsuit was commenced.

> This represented the Division's first formal attempt to deal with the problem of patients who refuse medication, and was in response to the issues raised in this litigation.

*Rennie v. Klein*, 476 F. Supp. 1294, 1303 (D.N.J. 1979). It is a fair inference that the Bulletin is nothing more than a response to the stimulus of a threatened court order. The implementation of the Bulletin was hardly enthusiastic. Although after March, 1979 the central office of the Division of Mental Health was supposed to review the case of any patient compelled to take medication, a representative of the office could confirm only two such reviews having taken place by late summer of that year, although 40 to 50 patients a month were recorded as refusing drugs at Marlboro Hospital alone. The witness added that a Dr. Rotov

> might have reviewed "several" other cases [besides Rennie's], and examined some patients personally. . . . The Court finds that this level of review is hardly a regular procedure, and is not quickly or reliably available to patients.

476 F. Supp. at 1303. The court found, moreover, that the Bulletin was not rapidly implemented at the various hospitals. It was ignored in two hospitals for nine months, and was not even called to the attention of the medical director of Marlboro Hospital for eight months. 476 F. Supp. at 1303. Given the evident lack of enthusiasm in the Division of Mental Health for addressing the problem in the first place, and for implementing the Bulletin after it was devised as a response to the lawsuit, the court's skepticism about relying on it as a substitute for an injunction is understandable.

I find it unnecessary to determine whether the Bulletin sets forth the process that is due. The opinion of the court does not refute plaintiff's evidence establishing that defendants have largely failed to comply with the procedures which it specifies. My principal disagreement with the majority is over the implicit suggestion that those procedures, though not implemented, nonetheless limit the remedial authority of the court to cure a substantive violation, because in the abstract or on their face they satisfy the minimum requirements of due process. The Bulletin cannot limit the scope of pendente lite injunctive relief. It must be recalled that the trial court has not yet acted finally. It concluded, however, based upon its evaluation of all the evidence and the testimony, that plaintiff class members were suffering irreparable harm and that, at least until it received further information, more protection against forced medication was, in the New Jersey institutional climate, required. To support that conclusion the court made detailed findings in light of which the preliminary injunctive relief it ordered was demonstrably not an abuse of discretion. *Oburn v. Shapp*, 521 F.2d 142 (3d Cir. 1975); see also *Doran v. Salem Inn*, 422 U.S. 922 (1976).

For example, the court found, significantly, that refusals had been underreported since the Bulletin's adoption:

A major problem in implementation of Bulletin 78-3 is identifying those patients who refuse drugs. At Marlboro Hospital about 40 to 50 patients a month have been recorded as refusing. Tr. XXIX, 80, 87-88; Ex. D-34, pp. 45-48. Trenton Hospital has reported about 15 to 40 a month. Ex.D-38, pp. 46-49. Ancora Hospital has invoked the Bulletin for only Mr. Rennie and the 23 year old woman discussed above. No other patient has been reported to have refused since the beginning of the year. Ex. P-33, p. 77; Ex. D-35, pp. 24-26. Greystone has only reported three patients refusing since the beginning of the year. Ex. P-33, pp. 80-81; Ex. P-47, pp. 29-31, and the Gardner Geriatric Center has only acknowledged one refusal. Ex. D-47, pp. 26-28; Ex. J-6, p. 24.

The record also reflects the fact that in a ward of 70 patients at Boston State Hospital, which has been prohibited from forcing medication by federal court order, 10 to 12 patients refuse medication at any one time. Tr. XXVII, 35-36. A psychiatrist with experience at state hospitals in New York testified that five percent of patients refuse medication at a given time. Tr. XXVIII, 12.

The patient populations at Trenton, Marlboro and Boston State are similar to those at Greystone and Ancora. The court attributes the discrepancy in statistics to a substantial failure by staff at the latter hospitals to report refusals. Also, certain hospitals overuse the exception in the Bulletin for emergency situations. Tr. XXX 17.

476 F. Supp. at 1303-04. The court's factual findings that staff members have failed to report refusals and have abused the "emergency" exception in the Bulletin are not clearly erroneous. The court also found that many patients are too intimidated to refuse medication and thereby trigger the review procedures in the Bulletin.

> Even if all hospitals accurately reported the number of overt refusals by patients, many patients are too intimidated to attempt to refuse medication and would still be ignored. Certainly there has been extensive use of forced injections in the hospitals when both voluntary and involuntary patients refused to take medication orally. Tr. XVIII, 71, 75, 88, 115; Tr. XX, 8-20; Tr. XXII, 18-20, 104; Tr. XXIII, 74-76; Tr. XXIX, 112-19; Tr. XXXI, 95-107; Tr. XXXII, 65; Ex. P-28, p. 11; Ex. P-35, p. 6; Ex. P-60; Ex. P-61; Ex. P-65; Ex. P-75. The Marlboro medical director candidly admitted that drugs are still systematically forced on patients. Tr. XXIX, 137. Often forced injections are doses of long-acting prolixin which not only has a much longer effect than other psychotropics but usually has more immediate adverse side effects. Tr. XXII, 104; Tr. XXXI, 108; Ex. D-23, 70-71; Zander, *Prolixin Decanoate: A Review of the Research*, in 2 Mental Disability L. Rep. 37-39 (1977). Therefore it would be quite rational for patients to conclude that resistance to drugs would result in their receiving a more unpleasant medication.

476 F. Supp. at 1304. This finding of intimidation is not clearly erroneous. Intimidation, if it exists, makes the Bulletin meaningless since it only applies to refusals of medication. The court also found that although a review is initiated only after a refusal to accept medication, there is little evidence that the hospitals have taken affirmative steps to inform patients of their right to refuse. 476 F. Supp. at 1304. Thus the court found that a combination of underreporting, intimidation, and induced ignorance, seriously undermined confidence that the review procedures of the Bulletin would ever become readily available to members of the plaintiff class.

For those instances in which refusals of medication actually occur, the court's findings cast doubt upon the

effectiveness in actual operation of the Bulletin's procedures.

Much of the evidence concerning use of Bulletin 78-3 focused on review by the medical director of refusals by involuntary patients. Few of the recorded refusals even reach that level, partly as a result of legitimate and desirable agreement by patients with their doctors or treatment team to take some medication, and partly the result of wrongful coercion of patients. The Marlboro medical director overruled three of the ten cases which reached his desk since adoption of the Bulletin. Tr. XXIX, 21-22; Ex. D-34, pp. 45-47. The Ancora medical director upheld the treating physician in the two cases referred to him. Tr. XXXIII, 71; Ex. D-35, pp. 24-26. The same statistic applies to Greystone. Tr. XXXI, 14; Ex. P-47, pp. 29-31. At Trenton, the medical director rescinded half of the six forced medication orders she reviewed. Ex. D-38, pp. 46-49. There is no evidence of any decision reaching the medical director at Gardner. Ex. D-36, pp. 45-47.

The court does not find these statistics themselves indicative of the capability or independence of the medical directors. But these officials can be faulted for their failure to insure that the Bulletin is fully implemented, that patients' refusals are acknowledged and counted, and that force and threat of force or punishment is not used to administer medication.

The medical directors asserted in their testimony that they indeed can exercise independent and conscientious reviews. Tr. XXIX, 21-22; Tr. XXXI, 13; Tr. XXXIII, 40. But some of the individual cases described above rebut those assertions. The Greystone medical director even delegated his responsibility to every staff psychiatrist under a clause in the Bulletin which allows another doctor to act

> for the medical director when he is away; however, this interpretation was later overruled by Dr. Rotov. Tr. XXXI, 48-49. The Ancora medical director testified that, in his opinion, an emergency justifying forced medication could last over 30 days. Ex. P-29, p. 31. *In fact, the medical directors have not even acknowledged a constitutional right to refuse treatment or followed the court's guidelines on the law in deciding refusal cases.* Tr. XXIX, 21; Tr. XXXIII, 40.
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> *The medical directors' actions demonstrate a lack of independence and objectivity when reviewing the actions of their staffs.* The court believes this stems largely from their responsibilities; they must have the support of their personnel, whose jobs are made easier when patients are subdued by medication. Unfortunately the rights and health of patients are sometimes ignored.

476 F. Supp. at 1305 (emphasis supplied). These findings, not clearly erroneous, certainly support the court's conclusion that something more than reliance on the Bulletin was appropriate.

The majority disregards these findings and substitutes its own intuitive judgment that the Bulletin will "if carefully followed, pose only a minor risk of erroneous deprivation." Typescript p. 25. It bears repeating, however, that a pattern of patient abuse, mistaken diagnoses, and inadequate record-keeping has been documented. The medical directors have denied the very existence of an underlying right to refuse treatment and the appellants still contest its existence on appeal. Whatever may be said about the contours of procedural due process in the abstract, concretely the court had the obligation to attempt to fashion a temporary injunction which would be effective in bringing the pattern of substantive violations to an end. Plainly it cannot be considered an abuse of discretion for the court to have concluded that a more independent review was required than

that proposed as a litigation response by the reluctant defendants. Nor did the court misconstrue Supreme Court precedents or apply erroneous legal standards.[1]

1. Indeed, the Supreme Court has not foreclosed the possibility that institutional pressures or biases may disqualify a decision-maker; it has required impartiality and detachment and said that a staff physician will suffice "so long as he or she is free to evaluate independently" the evidence. Parham v. J.R., 442 U.S. 589, 607 (1979); *see also* Wolff v. McDonnell, 418 U.S. 539, 559 (1974); *Morrissey v. Brewer*, 408 U.S. 471, 489 (1972). In each of these cases, a district court finding that intramural administrators were fit to review decisions made by their subordinates was affirmed by the Court expressly *on the record* and not as a matter of law. *See, e.g.*, Parham v. J.R., *supra*, 442 U.S. at 618; Wolff v. McDonnell, *supra*, 418 U.S. at 571. Accordingly, even were the injunction before us a permanent one, the question whether medical directors in New Jersey mental hospitals lacked the objectivity necessary to review the actions of their staff should be subject to the clearly erroneous standard of review.

Likewise, the Supreme Court has recognized that some provision for patient advocacy, such as the district court ordered in this case, may be the unavoidable price of due process when those persons whose liberty interest is threatened are particularly vulnerable or helpless. *See* Vitek v. Jones, 445 U.S. 480 (1980). Frowning on the adversariness implicit in such a decree, the opinion of the court vacates it in reliance upon *Parham v. J.R.*. The analogy is misplaced, however, since the doctors there served as a disinterested check on the decisions of parents affecting their children. In the context of involuntary drugging, however, the doctors are called upon to review the decisions of colleagues or subordinates within their institution.

In the more comparable context of *Vitek v. Jones*, the Court found the risk of error in determining a prisoner's need for compelled behavior modification treatment to be "substantial." Acknowledging that the inquiry involved was essentially medical, and that officials with medical, rather than legal training should make the decisions, the Court nonetheless responded that "[i]t is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings." 445 U.S. at 495, *quoting* Addington v. Texas, 441 U.S. 418, 430 (1979). A majority of the justices agreed that due process under such circumstances required the provision of "independent assistance" to an inmate, so that his interests would be effectively advocated at the hearing. 445 U.S. at 498 (Powell, J., concurring).

With respect to the need for greater independence, the court found:

> Certain testimony concerned plaintiffs' request for independent review by some type of hearing board or examiner of decisions to forcibly medicate. The court accepts the opinions of those experts who indicated that someone outside the hospital structure would provide a fairer, more accurate review of patients' refusal rights. Tr. XVII, 85; Tr. XXIV, 108-11; Tr. XXVI, 58; Tr. XXXII, 160-63.
>
> The court also believes that if an independent check on forced medication is established, doctors would learn the legal limits of involuntary medication and the number of attempts to force psychotropics would eventually decrease. This would also mean that the number of cases reaching an independent decision-maker would eventually drop to a relatively small number of disputes. The court cannot specifically gauge the cost of an independent review system, but it rejects the $3 million per year figure provided by defendants, Tr. XXX, 42-46, as based on overestimates of the number of reviews and the number of hours required for each hearing.
>
> More sensitivity on the part of treating physicians would also engender better patient-doctor relations. Less use of psychotropics and more attention to patient's feelings about their treatment would likely improve patient-staff relations and foster patients' individual dignity. Tr. XXIX, 19, 78-79, 89-90. While the authority granted an outside review officer will initially cause resentment among

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By discounting the need for independent decisionmakers and patient advocates without regard to the risk of error demonstrated in the record, the opinion of this court seriously blunts the significance of the foregoing Supreme Court precedents.

> many doctors and staff members of the hospital, Tr. XXVII, 49; Tr. XXXIII, 43, the court believes that a carefully structured review system would eventually be accepted by most personnel as review under the Bulletin has been accepted. Tr. XXIX, 19; Tr. XXXI, 18; Ex. P-29, p. 47.

476 F. Supp. at 1306. These findings, which involve credibility determinations, are not clearly erroneous. They suggest the need to take steps to educate the reluctant defendant doctors in becoming sensitive to patients' constitutional rights, the existence of which, even today, they deny.

Moreover the court in the quoted findings rejects the defendants' overblown estimates of cost of the independent review system it ordered. The majority, while not expressly reversing this credibility judgment, notes its acute awareness of finite state resources (Typescript p. 27). However, aside from the exaggerated estimate which the trial court refused to accept, there is no record evidence from which it can be concluded that the system which the trial court ordered will involve any net cost. There is abundant evidence of excessive reliance upon psychotropic drugs. No evidence was presented as to the cost of those drugs, but it is quite possible that the effect of enforcing patients' rights in this area would be to reduce the hospital's overall medication budget.[2] The majority's discussion of finite state resources is rank speculation.

Even less defensible is the majority's decision to vacate that part of the preliminary injunction which directs the defendants to submit to the court monthly re-

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2. Ancora Hospital reported that because of changes in response to the *Rennie* litigation, $100,000 was saved on medications in one year. Indeed, comparable savings in other hospitals might offset the cost of independent review and patient advocacy. *See* A.D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull. Am. Acad. Psychiat. & L. 179, 202 (1981).

ports describing in reasonable detail their implementation of the Administrative Bulletin and the court's order pending entry of a final order. 476 F. Supp. at 1315. This elementary precaution, designed to enlighten the court as to the appropriate contours of final injunctive relief, has been vacated without discussion, despite the fact that the district court retains jurisdiction to consider at a later date the need for measures to enforce compliance with the procedures contained in Bulletin 78-3. Respectfully, I ask my colleagues how that provision can, under under any definition of the term, be deemed to be an abuse of discretion. Certainly the judge is entitled to know whether the steps which have been taken as a result of the lawsuit have actually been effective in bringing to an end the pattern of violations of constitutional rights which, he found, were committed by health professionals. Judge Brotman was hardly donning a white coat, as the majority opinion suggests, when insisting that information essential for the formation of an informed judgment at final hearing be preserved and brought to his attention.

Part III of the majority opinion contains at least three fundamental errors. First, it disregards the trial court's factual findings. Second, it departs from the appropriate standard of review of district court discretion with respect to pendente lite relief. Third, it confuses the standard for injunctive relief from an established pattern of illegal conduct with the distinct question of what, in the abstract and absent such an established pattern, would be an appropriate procedural rule for safeguarding a substantive right. The last error is the most egregious. The case before us is not one in which the defendants admit the existence of the substantive right and plaintiffs direct their challenge solely to the sufficiency of the state procedures *on their face*. Rather the record demonstrates that in practice these procedures have failed to protect plaintiffs' substantive liberty interest.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

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Nos. 79-2576 and 79-2577

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JOHN E. RENNIE, Plaintiff on behalf of himself and all others similarly situated, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI, Intervenors, on behalf of themselves and all others similarly situated,
*Appellants/Cross Appellees*

*v.*

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital, ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,
*Appellees/Cross-Appellants*

(D.C. Civil No. 77-2624)

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

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Argued April 22, 1980

Before: ALDISERT, WEIS and GARTH, *Circuit Judges*

Reargued In Banc May 12, 1981

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Appendix B 1

thus entitling them to the protection of the court's broad remedial powers. We are dealing then with more than a dispute over what minimum procedural due process the fourteenth amendment requires for the protection of an acknowledged right. *Cf. Matthews v. Eldridge*, 424 U.S. 319 (1976). Clearly a court, faced with defendants who dispute the very existence of the constitutional right at stake, may supplement such minimum safeguards if, within its sound discretion, it concludes that this is necessary to the fashioning of effective pendente lite relief. *See, e.g., Todaro v. Ward*, 565 F.2d 48, 52-53 (2d Cir. 1977); *Morris v. Transano*, 509 F.2d 1358 (1st Cir. 1975); *cf.* 28 U.S.C. §1651. The emotional negative response which our recognition of basic human rights for the involuntarily committed evokes in some quarters should not lead the majority of the court to announce an opinion which in this and other contexts will have unfortunately inhibiting consequences upon the ability of trial judges to fashion effective injunctive relief.

Thus I dissent from Part III of the opinion of the court and from the judgment. I would affirm the district court order in all respects.

A True Copy:

Teste:

*Clerk of the United States Court of Appeals*
*for the Third Circuit*

(AO U. S. Courts: The Legal Intelligencer, Phila., Pa.) 55

Before SEITZ, *Chief Judge*,
ALDISERT, ADAMS, GIBBONS, HUNTER, WEIS, GARTH,
HIGGINBOTHAM and SLOVITER, *Circuit Judges*

(Opinion filed July 9, 1981)

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**ORDER AMENDING OPINION**

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The slip opinion in the above matter is hereby amended as follows:

Page 64

In the last line of the third full paragraph insert a comma following "XXX"

In the last line on the page there is a colon following "Bulletin"

Page 65

In the fifth line from the bottom, remove the comma following "ignorance"

Page 66

In the second line the word "procedures" is followed by a colon.

Page 68

In the seventh line of footnote 1, "Morrissey v. Brewer" is not to be in italics.

In the first line of the third full paragraph of footnote 1, remove the word "more"

Page 69

In the first line of the continuation of footnote 1, "decisionmakers" should be "decision-makers"

Page 70

In the fifth line of the first full paragraph "Typescript" should be changed to "typescript"

Page 71

In the 10th line remove the word "under"

JOHN J. GIBBONS
*Circuit Judge*

DATED: July 20, 1981

A True Copy:

Teste:

*Clerk of the United States Court of Appeals*
*for the Third Circuit*

No. s. 79-2576/7

JOHN E. RENNIE

vs.

ANN KLEIN, COMMISSIONER OF HUMAN SERVICES; MICHAIL ROTOV, DIRECTOR, DIVISION OF MENTAL HEALTH AND EXECUTIVE OFFICER OF ANCORA PSYCHIATRIC HOSPITAL; MIA PEPERNICK, ACTING MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL; EDWARD WALLACE, ASSISTANT ADMINISTRATOR OF ANCORA PSYCHIATRIC HOSPITAL; and JOSEFINA BUGAOAN, ASSISTANT MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL

John E. Rennie, plaintiff, on behalf of himself and all others similarly situated, and Caroline Mauger, Eugenie Burgess, Leon Rossi, Hazel Honorief, Ernie Welker, Mary Jane Weiss, Margaret Mary McGrath and Joseph Kozlowski, Intervenors, on behalf of themselves and all other similarly situated, Appellants, No. 79-2575

Ann Klein and Michail Rotov, Appellants, No. 79-2577

(D. C. Civil No. 77-2624)

Present: HUNTER, VAN DUSEN and SLOVITER, Circuit Judges.

1. Motion by Ann Klein and Michail Rotov, appellees, cross-appellants, to issue a stay of the District Court preliminary injunction order filed September 14, 1979, pending appeal, with brief, and Appendix, Volume I, and Appendix, Volume II, in support of motion,

in the above-entitled cases.

Respectfully,

Clerk

ald
enc.

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The foregoing Motion is/are denied. The Clerk is directed to expedite the listing of this appeal for submission at the earliest convenient time of the Court.

By the Court,

Judge

Dated: January 25, 1980

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

JOHN E. RENNIE,

Plaintiff,

CAROLINE MAUCER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI,

Intervenors, on behalf of themselves and all others similarly situated,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNICK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

Defendants.

Civil Action No. 77-2624

ORIGINAL FILED
SEP 14 1979
ANGELO W. LOCASCIO, CLERK

OPINION ON PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

APPEARANCES:

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Appendix D

BROTMAN, District Judge

This is a motion for a preliminary injunction by a class composed of patients in five hospitals for the mentally ill operated by the State of New Jersey. Plaintiffs seek to restrain the hospitals and their staffs from forcibly administering drugs to them unless a hearing is held and certain conditions are met. The court holds that plaintiffs do have a constitutional right to refuse medication in certain circumstances, and has fashioned a decree to enforce that right.

PROCEDURAL HISTORY

This litigation began when a complaint was filed by plaintiff John K. Rennie on December 22, 1977. The defendants were Ms. Ann Klein, Commissioner of the Department of Human Services of the State of New Jersey, Dr. Michail Rotov, Director of the Department's Division of Mental Health and Hospitals, and various officials at Ancora Psychiatric Hospital, where Mr. Rennie is an involuntarily committed patient. The complaint charged defendants with violations of four rights: (1) the right to refuse medication in non-emergent circumstances, (2) the right to treatment, (3) the right of access to counsel, and (4) the right to be free from physical abuse while in custody.

Since the c aplaint was filed, the litigation has focused on the right to refuse treatment, and, tangentially, on the right to counsel, while the rights to adequate treatment, safe confinement, and access to counsel generally have been reserved for later consideration. On December 20, 1978, the court imposed a temporary restraining order on defendants preventing them from medicating Mr. Rennie against his will beyond a maintenance dosage except in emergencies. Plaintiff then moved for a preliminary injunction and the court held fourteen days of hearings between January 13 and April 28, 1978. On April 18, 1978, the temporary restraining order was dissolved after a consensus was reached concerning the proper treatment for Mr. Rennie at that time. However, on May 19 the plaintiff again sought temporary relief, which was denied pending a resolution of the preliminary injunction motion.



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The court issued its decision on November 9, 1978. The opinion, reported at 462 F. Supp. 1131, provides a detailed chronicle of Mr. Rennie's medical history and the litigation up to that time. It also discusses the beneficial and detrimental effects of various medications and the several legal theories asserted by plaintiff to support a right to refuse treatment.

This court concluded that a right to refuse should be recognized, based on the constitutional right of privacy. 462 F. Supp. at 1144-45. However, because of countervailing state interests, the right must be a qualified one, and the following four factors must be considered in applying the right in a given situation: (1) the patient's physical threat to other patients and staff at the institution, (2) the patient's capacity to decide on his particular treatment, (3) the existence of any less restrictive treatments, and (4) the risk of permanent side effects from the proposed treatment. Id. at 1145-48.

This court also stated that a mental patient has a right to procedural due process, and noted in dictum that this might include a hearing and representation by a lawyer and independent psychiatrist before drugs are forcibly administered in a non-emergent situation. Id. at 1147-48.

It was held that, because of the extended court hearings, Mr. Rennie had received all the process which he was due. Id. at 1147. It was also noted that Mr. Rennie was not receiving undesired medication; therefore no injunction was issued. Id. at 1148 & n.6. However, Mr. Rennie's condition worsened shortly after that time and the hospital again sought to administer thorazine against the patient's will. After a hearing on December 7, 1978, the court denied Mr. Rennie's renewed motion for a preliminary injunction. In an opinion issued December 12, the court found that Mr. Rennie's capacity was severely limited at that time and that thorazine was the least restrictive means of stabilizing his condition. Therefore, the four factors indicated that an injunction

should not issue. 446 F. Supp. 1151, 1153.[1]

At this time plaintiff moved to enlarge his suit to a class action. By order dated March 20, 1979, the court allowed plaintiff to amend his complaint to add class action allegations, allowed various intervenors to join the action as plaintiffs and conditionally certified three subclasses pursuant to Fed. R. Civ. P. 23(b)(2). The first subclass is composed of all persons who presently are or in the future may be hospitalized at Ancora Psychiatric Hospital. This subclass, according to the amended complaint, alleged violation of the rights to adequate treatment and safe confinement. The court has not yet been asked to hear the claims of this group.

The court also conditionally certified two statewide subclasses asserting the right to refuse treatment and to due process before treatment is forcibly administered. The amended complaint focused exclusively on the forcible administration of medication. See ¶ 13A. One subclass is composed of all adult patients involuntarily committed to five mental health facilities operated by the Division of Mental Health and Hospitals. The other subclass is composed of voluntarily committed adult patients at the five facilities: Ancora Psychiatric Hospital, Marlboro Psychiatric Hospital, Trenton Psychiatric Hospital, Greystone Park Psychiatric Hospital, and the Glen Gardner Center for Geriatrics.[2]

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1. After an initial regimen on the unwanted drug, thorazine, Mr. Rennie's condition again stabilized and has been generally good to date. At the present time he is voluntarily taking lithium carbonate and has been granted extended furloughs from the hospital. However, he still retains the status of an involuntary patient.

2. The statewide subclasses originally included minor as well as adult patients at the five hospitals and a sixth facility exclusively for children, the Arthur Brisbane Child Treatment Center. However, by a bench opinion on August 22, the court recertified the subclasses, creating two distinct statewide subclasses for voluntary and involuntary patients under the age of 18. The court also denied the preliminary injunction for these patients, concluding that plaintiffs, who had focused almost exclusively on the problems of adult patients during the hearings, had not provided adequate proof concerning the treatment of minors and the role of parents and guardians in determining minor patients' right to refuse.

After extensive discovery, these two subclasses moved for a preliminary injunction to restrain the use of psychoactive drugs without the freely given consent of the patient and without procedural safeguards. The court held 17 days of hearings between June 13 and August 9, 1979. Transcripts (Tr.) XVII - XXXIII. The parties also supplemented the record with numerous depositions and exhibits.

The court heard testimony of several patients and staff personnel from the various facilities and was provided extensive medical records. Both sides produced highly qualified experts in psychiatry, psychopharmacology and hospital administration. Numerous scholarly articles were submitted. Courtroom or deposition testimony was provided by each of the five medical directors, who are the chief psychiatrists at the hospitals and supervise medical practices. This testimony was supplemented by memoranda, records and statistical studies concerning the use of medication at the facilities. A Division attorney who has addressed these issues also testified at length.

The following are the court's findings of fact and conclusions of law pursuant to Fed. R. Civ. P. 52(a).

## FINDINGS OF FACT

### I. Benefits and Side Effects of Psychotropic Medication

The benefits and side effects of psychotropic drugs were discussed in Part IV of the findings of fact in the November opinion. 402 F. Supp. 1136-38. Those findings are adopted and incorporated here. The court found that while psychotropic drug treatment had shown considerable success, recent studies had raised questions about the efficacy of using psychotropics in every case of mental illness. The present record provides additional evidence that many patients who would normally be treated with psychotropics can improve without them, and that smaller doses than are traditionally given can often be effective. Tr. XVII, 50-51; Tr. XXIV, 39; Tr. XXIX, 65; Crane, Clinical Psychopharmacology in Its 20th Year, 181 Science 124 (1973) (Exhibit P-46); Gardos & Cole, Maintenance Antipsychotic Therapy: Is the Cure Worse than the Disease? 133 Am. J. Psychiatry 32 (1976)

(Ex. P-46). The drugs are most useful in diffusing schizophrenic thought patterns during acute psychotic episodes. Tr. XVI, 106-09; Tr. XXVI, 36; Tr. XIX, 58-59; Tr. XXVII, 31-32.

The evidence at the recent hearings also reconfirmed the fact that these drugs have dangerous side effects, including tardive dyskinesia. Tr. XIX, 41; Tr. XXI, 47; Tr. XXVI, 40-50. Testimony also indicated that the drugs inhibit a patient's ability to learn social skills needed to fully recover from psychosis, and might even cause cancer. Tr. XXVI, 41, 48. Even acutely disturbed patients might have good reason to refuse these drugs. Tr. XXXI, 66.

## II. The Hospitals

### A. Patient Population and Staffing

Ancora Psychiatric Hospital is a state facility for the mentally ill in Hammonton, New Jersey. It houses about 1000 patients at any one time. Tr. XXII, 37; Ex. P-42, p. 1. Marlboro Psychiatric Hospital is a state facility in Marlboro, New Jersey, with a patient population of approximately 800. Ex. P-42, p. 1. Greystone Park Psychiatric Hospital, in Morris Plains, New Jersey, has a population of 1100. Tr. XXXI, 90; Ex. P-42, p. 1. Trenton Psychiatric Hospital in Trenton has about 1000 patients. Ibid. The Glen Gardner Geriatric Center in Glen Gardner, New Jersey, has about 140 patients; all are of advanced age and have been transferred from Trenton Psychiatric Hospital.

The four large hospitals have fairly similar populations. The majority of patients in each hospital are diagnosed schizophrenic; about 25 percent are categorized as having organic brain syndrome. About five percent are diagnosed as suffering major affective disorders, and another five percent are believed to be mentally retarded. Ex. P-42, pp. 35-42. The patients at Gardner are no longer in need of acute psychiatric care, but were formerly hospitalized for mental illness and often continue to receive psychotropic medication. Ex. J-6, pp. 3-5.

The hospitals are understaffed and patients have trouble seeing psychiatrists. Tr. V, 61-63; Tr. XXII, 7, 136. They generally have large, bleak and unpleasant wards, and the patients have little structured activity. Tr. I, 46-47; Tr. XIV, 165-67; Tr. XXVI, 18-20.

B. Use and Effect of Psychotropic Drugs

A vast majority of patients at the five hospitals receive psychotropic medications, either by pills or injection. Tr. XXII, 54-55; Ex. D-23, p. 74; Ex. J-6, p. 36. One expert testified that drugs are the "be all and end all" at the hospitals. Tr. XXXI, 165. The medical director of Marlboro states in an office memorandum that the hospital "uses medication as a form of control and as a substitute for treatment." Ex. P-47, p. 15. A 1975 study of these institutions found overuse of drugs and inadequate record-keeping. Ex. P-47, pp. 84-86. The pattern of drug usage appears to be no different than that of other large state institutions, which was described in an article by Dr. George Crane, a psychiatrist who testified at the hearings:

> Many physicians, nurses, guardians, and family members who resent the patient's behavior and are threatened by potential acts of violence fail to distinguish between manifestations of illness and reactions to frustrations. Hence, drugs are prescribed to solve all types of management problems, and failure to achieve the desired results causes an escalation of dosage, changes of drugs, and polypharmacy. It is often reported that patients refuse to ingest their pills or that relatives fail to supervise the proper administration of medicines. Less publicized is the patient's dependence on drugs. The medical staff gains a feeling of accomplishment from the patient's adherence to a prescribed regime, while the nursing personnel and relatives, who are in more direct contact with the patient, derive a spurious feeling of security when the doctor's orders are carried out. Thus, the prescribing of drugs has in many cases become a ritual in which patients, family members, and physicians participate.... [N]euroleptics are often used for solving psychological, social, administrative, and other nonmedical problems.

Crane, **supra**, at 125.

This extensive use of psychotropics has caused numerous patients not only transient side effects, Tr. XXII, 134, but permanent

neurological damage including tardive dyskinesia[3] and drug-induced parkinsonism. The medical director of the Gardner Geriatric Center estimated that 35 to 50 percent of his patients--all transferred from Trenton Hospital wards--have tardive dyskinesia. Ex. J-6, pp. 3-4. The medical director of Ancora testified that the rate of tardive dyskinesia among his patients was probably between 25 to 40 percent, based on national studies, although he could not estimate from data generated at his own hospital. Ex. P-29, p. 3; Tr. XXII, 82. In fact, none of the medical directors had a clear idea of the extent of tardive dyskinesia among their patients. Tr. XXXII, 33; Ex. D-23, p. 28; Ex. J-6, p. 4; Ex. J-7, p. 46. Dr. Crane, a leading expert in the study of tardive dyskinesia, examined patients at two of the hospitals and found significant number of persons with tardive dyskinesia and other potentially permanent side effects which had not been diagnosed and charted in the patients' records. Tr. XVII, 25-38.

Despite much criticism from outsiders, little was done by defendants to improve medication procedures until November 1978. At that time Commissioner Klein issued Administrative Order 2:13, Ex. D-21, and Dr. Rotov issued accompanying Administrative Bulletin 78-6, Ex. D-21. These documents provide specific guidelines to insure careful and knowledgeable administration of psychotropic drugs, and mandate that extrapyramidal symptoms be closely monitored. In particular, a check list for abnormal involuntary movement syndromes, or AIMS form, must be completed every three months. Ex. D-31. The court finds that these guidelines, modeled closely after a document used by the Michigan Department of Mental Health, Ex. P-47, pp. 48-52, are well intentioned and reflect a reasoned approach to the use of psychotropic medication.

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3. Doctors have recently studied ways to reverse the effects of tardive dyskinesia, and have had some tentative successes in certain types of patients. Gelenberg, Doller-Wojcik & Growdon Choline and Lecithin in the Treatment of Tardive Dyskinesia: Preliminary Results from a Pilot Study, 136 Am. J. Psychiatry 772 (1979)(Ex. D-49); Jus, Jus & Fontaine, Long Term Treatment of Tardive Dyskinesia, 40 J. Clin. Psychiatry 72 (1979)(Ex. D-48).

However, plaintiffs have demonstrated a widespread failure to have the guidelines implemented. For instance, while AIMS forms have been completed for most patients in the five facilities, Tr. XVII, 79; Tr. XXVI, 14; Tr. XXIX, 4, 28; Ex. J-6, pp. 6, 27, the doctors using the forms have often failed to diagnose tardive dyskinesia and drug-induced parkinsonism. Tr. XVII, 25-38; Tr. XXII, 145-46; Tr. XXXI, 64-65; Ex. P-71, pp. 3,5; Ex. J-6, p. 44. It is not always clear whether nurses are completing the forms instead of physicians. Tr. XXXI, 62.

Furthermore, the court believes that medication decisions are often left to nurses or even attendants because the doctors will ratify their recommendations without examining the patient involved. Tr. XXIII, 56-59. There is also overuse of medication orders which specifically leave discretion to the staff for many days, or weeks, despite hospital rules against such practice. Tr. XXIX, 98-100; Ex. D-23, pp. 42-43; Ex. P-48. Doctors also continue to use poor medication practices, such as unjustified polypharmacy. Tr. XXXI, 103-09; Ex. P-29, p. 61.

The medical directors have begun to improve patient records, including pharmacy records, although there is still much to be done in this respect. Tr. XXII, 29, 73-80; Tr. XXIX, 18-25; Tr. XXXII, 70-73, 170-72; Ex. D-23, p. 40; Ex. J-7, p. 58. There has also been an attempt to better educate physicians in the use of psychotropics. Tr. XXIX, 28; Tr. XXX, 36-37; Ex. J-7, p. 58.

## III. Incidents Involving Individual Patients

Before turning to the general procedures concerning refusal of medication, the court will discuss the representative experiences of five of the many individual patients whose cases were brought to the court's attention during the hearings as indicative of the practices and policies of defendants Klein and Rotov and their hospitals. Although the names of all but one patient appear in the record, their names, with the exception of Mr. Rennie's, will not be used in this opinion.

The first patient is a 23 year old woman who was involuntarily committed to Ancora in 1978. She has had a history of mental illness and hospitalization since she was ten. Tr. XVIII, 82-85. At Ancora she was given psychotropic drugs which often blunted her consciousness to such an extent that she would spend much of the day sleeping. Id. at 86-87. Heavy doses were probably given in response to her quarrelsome and sometimes violent relationship with ward staff, which can, in large measure, be attributed to the fact that she felt unneeded and idle on the ward and was sometimes subject to physical assault from attendants. Id. at 90-101.

Until January 1979 she usually took medication without objection, and, on occasion, even requested it. Id. at 87, 106-07. However, she was also threatened with forced injection of medication when she expressed reluctance to take drugs. Id. at 88. In January she began openly resisting drugs because she had become pregnant and "did not want to hurt my baby." Id. at 89. In disregard of her pregnancy and her opposition to drugs, the treating physician persisted in prescribing psychotropics, and the patient was forced to complain to the Public Advocate's office, which interceded. Id. at 89, 103-05. Nevertheless, with the approval of the hospital medical director, Tr. XXXIII, 71, she was given haldol, a psychotropic, on March 16, 1979. Ex. P-54. One week later she ingested a small amount of detergent and was transferred to the hospital's medical unit. Id. That unit immediately stopped her use of haldol because of her pregnancy and because her diagnosis did not require use of psychotropics. Ex. P-29, pp. 52-54. The medical unit also allowed her to do small chores on the ward. Her general condition rapidly improved and she became very cooperative with ward staff. Tr. VIII, 94-95. On May 16 she was discharged and has remained off medication. Id. at 88, 96; Ex. D-14. Her demeanor when she testified in court was excellent.

In summary, despite the patient's hesitance and outright refusals, and her pregnancy, Ancora physicians on the psychiatric ward persisted in medicating this patient by force or intimidation when a change in environment was the least restrictive treatment indicated.

A change was, in fact, quite beneficial. However, only the patient's drastic action insured the transfer she needed and an independent evaluation by another doctor.

Another woman, 66 years old, was an involuntary patient at Greystone for 10 years. Plaintiff's expert diagnosed her illness as manic-depressive psychosis. Tr. XXXII, 58. The hospital had given her diagnoses of both manic-depressive psychosis and schizo-affective schizophrenia at different times. Id. at 59.

Recently this patient began refusing doses of thorazine, although she accepted lithium which is the drug of choice for manic-depressive illness. Id. at 60. Her refusal was, according to plaintiffs' expert, "very good judgment." Id. at 93. The expert credibly characterized the thorazine prescription as "grossly irresponsible," due to the reasonable success of lithium alone, her symptomatology, and particularly because the patient has tardive dyskinesia. Id. at 67-68.

In fact, a neurologist's report from 1975 in her medical record indicated she had a "classical" case of tardive dyskinesia, id. at 79, but his report was apparently lost in her records. Id. at 62. A January 1979 note in her record indicated that her jaw movements were "faking," id. at 65, although plaintiffs' expert testified that her movements were "so gross as to be unable to fake." Id. at 66. Indeed, because of her gross mouth movements from this disease she cannot be fitted with dentures and is forced to subsist on a diet of ground food. Ibid. She was also subjected to taunts from the hospital staff with the implication that the deformity was her own fault. Ibid.

Not only was thorazine prescribed, but it was also forced on this patient by injection at least once, in January of this year. Id. at 65.

Here, again, a psychotropic drug was involuntarily administered where there was little medical justification for the drug and great danger of creating or enhancing irreversible side effects. The side effects were blatantly ignored by doctors.

A third woman, a voluntary patient at Greystone, 60 years old, refused medication in August 1978 but was thrown onto a bed by attendants and given a long-acting form of prolixin by injection. The drug caused the patient severe discomfort. Tr. XVIII, 75-76; Tr. XXXII, 80-88. Plaintiffs' expert credibly testified that this was improper medication in this case and that the open ward privileges then given her were inconsistent with the suicidal diagnosis appearing in the patient's record. Tr. XXXII, 89-9-0. The expert believed many of her psychotic symptoms stemmed from her frustrations with hospital staff and delays in her discharge planning. Id. at 82-83.

The hospital medical director was involved in the decision to forcibly medicate this patient, and upheld the treating physician's decision based on the physician's reports. Tr. XXXI, 49-51. Review by an independent hearing officer before the forced injection might have aired this patient's complaints and may have prevented the questionable use of prolixin.

An intervenor in this action, age 29, was a voluntary patient at Ancora. Although the Public Advocate wrote a letter in March 1979 on the patient's behalf indicating the patient's dissatisfaction with his medication, long-acting prolixin, Tr. XX, 18; Ex. P-15, he continued to receive the medication. Tr. XVII, 114. At this time the hospital had him involuntarily committed, but did not follow Division procedures for involuntary patients who refuse medication. Ibid.

After several letters from the Public Advocate, the hospital responded by continuing prolixin but refusing to give cogentin, a drug which the patient wanted because it is used to alleviate certain painful side-effects of prolixin. Tr. XX, 37-38. Finally, in June of 1979 the patient was given another form of psychotropic, which caused him substantially less discomfort, and he was able to leave the hospital a few weeks later. Tr. XVIII, 118, 128.

Here, the intervention of the Public Advocate caused reprisals against the patient. The hospital failed to follow Division procedures for reviewing the refusals of involuntary patients, and subjected him to great suffering which could have been alleviated by simply changing from one psychotropic to another.

Turning to Mr. Rennie, the original plaintiff in this action and an involuntary patient at Ancora, the court first notes the imprudent use of prolixin which caused plaintiff to experience severe side effects. During the hearings in this litigation in 1978, his condition and treatment were brought to light before the court and were subject to the evaluation of psychiatrists outside the hospital. Through this process, the hospital acknowledged Mr. Rennie's aversion to the drug and agreed to give him another psychotropic. 462 F. Supp. at 1134-35.

The court is also concerned with the hospital's treatment of Mr. Rennie's extrapyramidal side effects. One nurse, who had recorded Mr. Rennie's abnormal jaw movements, was criticized and intimidated for her actions by doctors and nursing supervisors. Tr. XXIII, 62-64. Mr. Rennie's case has been continuously reviewed by the medical director of Ancora since this litigation began in 1977; he has approved forced administration of psychotropics. He has failed to record jaw movements indicative of tardive dyskinesia. Tr. XXXIII, 57, 59; Ex. D-44. However, movements have been detected by other personnel and plaintiffs' highly qualified experts. Tr. XV, 91-92; Tr. XVII, 35; Tr. XXII, 150; Ex. P-29, p. 83; Ex. P-56, p. 26. The medical director's questionable judgment in failing to acknowledge Mr. Rennie's jaw movements appears to be a result of institutional self-interest. A diagnosis of possibly irreversible side effects would impugn the wisdom of previous use of psychotropics and would necessitate less reliance on drugs in treating the patient in the future. Here, the medical director's review did not serve as an independent check free of these institutional pressures which result in unnecessary and harmful use of drugs.

## IV. Hospital Procedures Concerning Forced Medication

### A. Adoption and Initial Implementation of Bulletin 78-3

In March 1978, Dr. Rotov issued Administrative Bulletin 78-3, which is reprinted as an appendix to the November opinion. 462 F. Supp. at 1148-51. This represented the Division's first formal attempt to

deal with the problem of patients who refused medication, and was in response to the issues raised in this litigation. Ex. P-31, pp. 6, 72; Ex. D-23, p. 46.

The Bulletin, ¶ I(C)(3)(a), acknowledges the right of voluntary patients to refuse medication, which is provided by state law. N.J.Stat. 30:4-24.2(d)(1).

For involuntary patients, the Bulletin refers to a decision of the New Jersey Superior Court, In re Hospitalization of B, 156 N.J. Super. 231, 383 A.2d 760 (Law Div. 1977), which held that involuntary patients have no right to refuse. When an involuntary patient refuses, the Bulletin provides that the treating physician shall attempt to explain the risks and benefits of the drug. If refusal persists, the issue is to be discussed at a meeting of the treatment team, which is composed of the treating physician and various other persons at the hospital who deal with the patient, including psychologists, social workers and nurses. ¶ II(C). However, the team's collective opinion is only a recommendation to the treating physician. ¶ II(D).

Legally competent patients may have their cases heard by the medical director of the hospital. He must conduct a personal examination of the patient before approving involuntary medication. ¶ II(D). He may consult an independent psychiatrist if he wishes, and must review the patient's treatment program each week that the patient continues to protest his medication. ¶ II(E). The patient may have an attorney present during this process. ¶ II(B)(c); Tr. XXIX, 56; Tr. XXXI, 69.

The Office of the Commissioner also decided in March of this year that Dr. Rotov or another physician in the Division's central office should review the cases of any patient compelled to take medication by a decision of the medical director. Tr. XXX, 39-40, 38; Ex. P-47, p. 94. At the time of the hearing, however, a central office representative was able to indicate with certainty that Dr. Rotov reviewed the medical charts of Mr. Rennie and only one other patient. Tr. XXX, 91-94. The witness said Dr. Rotov might have reviewed "several" other cases, and examined some patients personally, id. at 40, 88. The

court finds that this level of review is hardly a regular procedure, and is not quickly or reliably available to patients. Id. at 88-89.

The Division central office has also failed to insure that the Bulletin was rapidly implemented. The testimony shows that it was completely ignored at least at Marlboro and Greystone until December 1978. Tr. XXIX, 19; Tr. XXXI, 11, 72; Ex. D-23, pp. 20-21. The medical director of Marlboro was not even told the document existed until November of last year. Tr. XXIX, 33.

B. Obtaining Consent and Acknowledging Refusals

A major problem in implementation of Bulletin 78-3 is identifying those patients who refuse drugs. At Marlboro Hospital about 40 to 50 patients a month have been recorded as refusing. Tr. XXIX, 20, 87-88; Ex. D-34, pp. 45-48. Trenton Hospital has reported about 15 to 40 a month. Ex. D-38, pp. 46-49. Ancora Hospital has invoked the Bulletin for only Mr. Rennie and the 23-year old woman discussed above. No other patient has been reported to have refused since the beginning of the year. Ex. P-33, p. 77; Ex. D-35, pp. 24-26. Greystone has only reported three patients refusing since the beginning of the year, Ex. P-33, pp. 80-81; Ex. P-47, pp. 29-31, and the Gardner Geriatric Center has only acknowledged one refusal. Ex. D-47, pp. 26-28; Ex. J-6, p. 24.

The record also reflects the fact that in a ward of 70 patients at Boston State Hospital, which has been prohibited from forcing medication by federal court order, 10 to 12 patients refuse medication at any one time. Tr. XXVII, 35-36. A psychiatrist with experience at state hospitals in New York testified that five percent of patients refuse medication at a given time. Tr. XXVIII, 12.

The patient populations at Trenton, Marlboro and Boston State are similar to those at Greystone and Ancora. The court attributes the discrepancy in statistics to a substantial failure by staff at the latter hospitals to report refusals. Also, certain hospitals overuse the exception in the Bulletin for emergency situations. Tr. XXX, 17.



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Even if [illegible] hospitals accurately recorded the number of overt refusals by patients, many patients are too intimidated to attempt to refuse medication and would still be ignored. Certainly there has been extensive use of forced injections in the hospitals when both voluntary and involuntary patients refused to take medication orally. Tr. XVIII, 71, 75, 88, 115; Tr. XX, 8-20; Tr. XXII, 18-20, 104; Tr. XXIII, 74-76; Tr. XXIX, 112-19; Tr. XXXI, 95-107; Tr. XXXII, 65; Ex. P-28, p. 11; Ex. P-35, p. 6; Ex. P-60; Ex. P-61; Ex. P-65; Ex. P-75. The Marlboro medical director candidly admitted that drugs are still systematically forced on patients. Tr. XXIX, 137. Often forced injections are doses of long-acting prolixin which not only has a much longer effect than other psychotropics but usually has more immediate adverse side effects. Tr. XXII, 104; Tr. XXXI, 109; Ex. D-23, 70-71; Zander, Prolixin Decanoate: A Review of the Research, in 2 Mental Disability L. Rep. 37, 39 (1977). Therefore it would be quite rational for patients to conclude that resistance to drugs would result in their receiving a more unpleasant medication. There is little evidence that the hospitals have taken affirmative steps to inform patients of their rights, Tr. XXIX, 30, although a pamphlet for patients is being prepared by the Division central office. Tr. XXX, 24-25; Ex. D-25, pp. 12-14, 19-20, 29-31.

Despite this situation, the hospitals only initiate review under the Bulletin where a patient affirmatively refuses to take a drug (assuming an overt refusal is acknowledged at all). Complaints or reluctance are not enough. Tr. XXII, 97-98; Tr. XXIX, 101-02, 136; Tr. XXXI, 99.

There has been recent discussion in the central office concerning the use of written consent forms for medication, Tr. XXX, 20; Ex. D-25, p. 12, but there are no specific plans to employ them.[4] Preparation of information pertaining to the harms, as well as benefits,

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4. It should be noted that even at Gardner Geriatric Center, where patients are generally the most incapacitated, consent forms are successfully used for drug experimentation. Ex. J-6, p. 14.

of drugs is also being considered in order to render medication consents informed. Tr. XXX, 21-25. Indeed, Marlboro and Ancora have started drug education classes and are preparing information forms; yet these lectures and material fail to disclose fully the danger of long-tem side effects including tardive dyskinesia. Tr. XVIII, 85; Tr. XXII, 86; Tr. XXIX, 30; Ex. D-23, pp. 32-34; Ex. D-34, pp. 12-27.

Another step that the Division has taken is the appointment of "patient advocates," one each at Marlboro and Ancora. Tr. XXX, 26. They are available to patients who have various problems, including complaints about medication. They can initiate review procedures under the Bulletin. Tr. XXIX, 13-14, 40, 61; Ex. P-29, pp. 98-100; Ex. D-23, pp. 57-63. See also Ex. D-18, pp. 91-92. The Marlboro advocate is responsible to that institution's chief executive officer (a non-medical administrator who is the highest officer at the institution), while the Ancora advocate is responsible directly to the Division central office. Tr. XXX, 26-27; Ex. D-23, p. 63. A Division official acknowledged during her testimony that the advocate should not be responsible to hospital officials so that he can pursue his independent advocacy role. Tr. XXX, 67-68. There are tentative plans to hire an advocate at each hospital. Id. at 28.

The Division of Mental Health Advocacy, Department of the Public Advocate, which represents the plaintiffs in this litigation, has legal and paralegal representatives at different hospitals who can assist patients in asserting their rights. However, this agency lacks the resources to provide services for all patients who do not or cannot consent to medication. Ex. D-25, pp. 27-28. The Department is generally charged with representing citizens on important matters in the public interest.

It should also be noted that some patients, particularly those on geriatric wards, are permanently out of touch with their surroundings and incapable of expressing informed consent, though few of these patients have been declared legally incompetent. Tr. XXII, 40; Ex. J-6, pp. 9-10, 32.



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C. Reviewing Refusals

Much of the evidence concerning use of Bulletin 78-3 focused on review by the medical director of refusals by involuntary patients. Few of the recorded refusals even reach that level, partly as a result of legitimate and desirable agreement by patients with their doctors or treatment team to take some medication, and partly the result of wrongful coercion of patients. The Marlboro medical director overruled three of the ten cases which reached his desk since adoption of the Bulletin. Tr. XXIX, 21-22; Ex. D-34, pp. 45-47. The Ancora medical director upheld the treating physician in the two cases referred to him. Tr. XXXIII, 71; Ex. D-35, pp. 24-26. The same statistic applies to Greystone. Tr. XXXI, 14; Ex. P-47, pp. 29-31. At Trenton, the medical director rescinded half of the six forced medication orders she reviewed. Ex. D-38, pp. 46-49. There is no evidence of any decision reaching the medical director at Gardner. Ex. D-36, pp. 45-47.

The court does not find these statistics themselves indicative of the capability or independence of the medical directors. But these officials can be faulted for their failure to insure that the Bulletin is fully implemented, that patients' refusals are acknowledged and counted, and that force and threat of force or punishment is not used to administer medication.

The medical directors asserted in their testimony that they indeed can exercise independent and conscientious reviews. Tr. XXIX, 21-22; Tr. XXXI, 13; Tr. XXXIII, 40. But some of the individual cases described above rebut those assertions. The Greystone medical director even delegated his responsibility to every staff psychiatrist under a clause in the Bulletin which allows another doctor to act for the medical director when he is away; however, this interpretation was later overruled by Dr. Rotov. Tr. XXXI, 48-49. The Ancora medical director testified that, in his opinion, an emergency justifying forced medication could last over 30 days. Ex. P-29, p. 31. In fact, the medical directors have not even acknowledged a constitutional right to refuse treatment or followed the court's guidelines on the law in deciding refusal cases. Tr. XXIX, 21; Tr. XXXIII, 40.

The medical directors' actions demonstrate a lack of independence and objectivity when reviewing the actions of their staffs. The court believes this stems largely from their responsibilities; they must have the support of their personnel, whose jobs are made easier when patients are subdued by medication. Unfortunately the rights and health of patients are sometimes ignored.

In many cases the patient's refusal of medication is prompted solely by the irrational components of his illness. Tr. XXVII, 51; Tr. XXVIII, 13; Tr. XXIX, 15; Tr. XXXI, 16. But refusals can also be prompted by a quite rational desire to avoid unpleasant side effects and a realistic appraisal that the medication is not helping one's condition, which are both subjective factors on which the patient may be the best authority. Tr. XXVII, 94-95; Tr. XXIX, 78-79; Tr. XXIV, 129; Tr. XXXI, 66.

The author of one study of why schizophrenic patients refuse drugs concluded that "the reluctance to take chemotherapeutic agents and the dysphoric response to antipsychotic drugs are usually related to [extrapyramidal side effects]." He also noted that much of the side effects "that led to drug reluctance [were] of the 'mild' or subclinical type which is apparent only to the careful observer.... the subtler extrapyramidal symptoms often go unrecognized by the physician--but not by the patient!" Van Putten, Why Do Schizophrenic Patients Refuse to Take Their Drugs?, 31 Arch. Gen. Psychiatry 67, 70, 71 (1974)(Ex. P-73). The same author found in another study that "the subjective response very early in chlorpromazine [thorazine, a psychotropic] treatment may predict, to a moderate degree, the symptomati outcome after a sustained course of treatment with the drug....schizophrenics have been asked every question except, 'How does the medication agree with you?' Their response is worth listening to." Van Putten & May, Subjective Response as a Predictor of Outcome in Pharmacotherapy, 35 Arch. Gen. Psychiatry 477, 478-80 (1978)(Ex. P-46).

The court is convinced that where patients' concerns and feelings may be more freely aired, and observable side effects are more closely monitored, medication will be used more wisely. If the refusals

of involuntary patients are fairly acknowledged and independently considered in accordance with the legal criteria, a significant number of patients will receive less or no medication, frequently to their benefit.

V. Independent Review

Certain testimony concerned plaintiffs' request for independent review by some type of hearing board or examiner of decisions to forcibly medicate. The court accepts the opinions of those experts who indicated that someone outside the hospital structure would provide a fairer, more accurate review of patients' refusal rights. Tr. XVII, 85; Tr. XXIV, 108-11; Tr. XXVI, 58; Tr. XXXII, 160-63.

The court also believes that if an independent check on forced medication is established, doctors would learn the legal limits of involuntary medication and the number of attempts to force psychotropics would eventually decrease. This would also mean that the number of cases reaching an independent decision-maker would eventually drop to a relatively small number of disputes. The court cannot specifically gauge the cost of an independent review system, but it rejects the $3 million per year figure provided by defendants, Tr. XXX, 42-46, as based on overestimates of the number of reviews and the number of hours required for each hearing.

More sensitivity on the part of treating physicians would also engender better patient-doctor relations. Less use of psychotropics and more attention to patient's feelings about their treatment would likely improve patient-staff relations and foster patients' individual dignity. Tr. XXIX, 19, 78-79, 89-90. While the authority granted an outside review officer will initially cause resentment among many doctors and staff members of the hospital, Tr. XXVII, 49; Tr. XXXIII, 43, the court believes that a carefully structured review system would eventually be accepted by most personnel, as review under the Bulletin has been accepted. Tr. XXIX, 19; Tr. XXXI, 13; Ex. P-29, p. 47.

The court further finds that independent review by psychiatrists rather than by judges, lawyers or laypersons, would provide the most

right to refuse treatment under state law. N.J.Stat. 30:4-24.2(d)(1). This right may be enforced in a civil action. N.J.Stat. 30:4-24.2(n). One part of the order is based on this right, heard as a pendent claim.[5]

It is not disputed that defendants acted under color of state law.

Plaintiffs do not ask the court to prohibit the administration of drugs to any particular patient. Rather they seek sweeping changes in hospital practices designed to protect their rights. Thus the crucial issue presented is what procedures are, at a minimum, required to protect the plaintiff's constitutional rights. While defendants have never acknowledged that a constitutional right to refuse exists, they also contend that procedures which have been instituted in the last year serve to meet any constitutional requirements.

In determining the procedures needed for affording members of both subclasses their constitutional right to refuse treatment, the court must consider the degree of vulnerability and helplessness of patients in the five hospitals, as well as the history of compelled medication through the use of forced injections which has created a general belief among many patients that medication cannot be refused. Given these realities--brought about by widespread improper practices on the wards--the court believes the constitutional right to refuse can be realistically afforded only if the hospitals, whenever possible, obtain specific, written consent from patients before they are medicated with any psychotropic drug. The hospitals must also inform patients of their rights and the potential side effects of medication in order that

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5. The court has jurisdiction over the constitutional claims of both subclasses under 28 U.S.C. § 1343(3). Exercise of pendent jurisdiction over claims based on the state law rights of voluntary patients is proper here because there is a common nucleus of operative fact linking that subclass' federal and state claims. See United Mine Workers v. Gibbs, 383 U.S. 715, 725 (1966). Pendent jurisdiction is justified on the grounds of judicial economy and convenience due to the court's extensive inquiry into hospital practices required by the federal claims alone. See id. at 726. As the voluntary subclass has both federal and state claims, jurisdiction over the state claim is based on the pendent claim doctrine, and not on pendent party jurisdiction through joinder with the federal claims of the involuntary plaintiffs. Therefore the jurisdictional bar of Aldinger v. Howard, 427 U.S. 1 (1976), is inapplicable.

accurate analyses of patient interests. Review within the profession would also create far less resentment among physicians and staff whose decisions are questioned. Tr. XXIII, 35; Tr. XXIV, 107; Tr. XXVII, 96-97, 106; Tr. XXVIII, 40. Informal inquiries would be superior to formal procedures because the latter would require more time and resources and often be more disruptive of patient-doctor relations, but would not significantly decrease the risk of erroneous determinations.

CONCLUSIONS OF LAW

I. Procedures Required

The evidence produced at this hearing reinforces the court's previous conclusion that a qualified right to refuse treatment should be recognized, and that due process must be provided before drugs can be forcibly administered. 463 F. Supp. at 1145-47. The rationale for these holdings need not be repeated here.

The due process holding is also strengthened by the Supreme Court's recent decisions in Parham v. J. R., 99 S.Ct. 2493 (1979) and Secretary of Public Welfare v. Institutionalized Juveniles, 99 S.Ct. 2523 (1979). These cases, which dealt with the due process rights of juveniles who were voluntarily committed to mental institutions by their parents, or by their state as guardian, held that commitment constitutes a deprivation of a protected liberty interest. 99 S.Ct. at 2503. This court feels that forced drugging can be as intrusive as the involuntary confinement resulting from commitment, and that drugging also has the potential for permanent deprivation through long-term side effects.

After consideration of the evidence at this hearing, the court further concludes that the privacy and due process rights previously recognized in Mr. Rennie's individual case should apply to all other members of the subclass of involuntary patients.

The same reasons compel recognition of the privacy right for voluntary patients. Much of the relief which the court will afford that subclass derives from this federal constitutional right. However, all parties recognize that voluntary patients have an absolute

all consents be properly informed.

Both subclasses are entitled to this procedure as both hold the constitutional privacy right. Whether New Jersey law requires the same specific consent for voluntary patients need not be determined here. However, the court does construe New Jersey law to mean that once a voluntary patient withholds under this procedure, the hospital cannot medicate in a non-emergent situation. Accordingly, there is no need for a due process hearing for these patients. Of course, appeals to the voluntary patient by the treatment team or medical director in order to obtain his freely given consent are proper.

On the other hand, the informed refusal of an involuntary patient may be overridden, as these patients' right to refuse is a qualified one. Any forced medication decision must be made by considering the four factors outlined in the court's November opinion. As forced medication implicates a sufficient liberty interest, due process safeguards must be instituted as part of this determination. The court, in dictum in its November opinion, noted some of the procedures which might be necessary. 462 F. Supp. at 1147-48. See also Task Panel Reports Submitted to The President's Commission on Mental Health 1435-36 (1978).

The Supreme Court's subsequent opinions in Parham and Institutionalized Juveniles must be considered in determining what process is due. The Court in those cases held that the district courts below had erred in requiring formal hearings before minors were committed These holdings are not strictly applicable to the forced administration of drugs to involuntary adult patients since the Supreme Court's decision was in large part based on its great concern with governmental interference with parental decisions about their minor children. 99 S.Ct. at 2507. Even so, the Court held that a "neutral factfinder" must review the parents' commitment decision. Id. at 2506.

This court believes that a neutral, independent decision-maker is also crucial in the treatment context, and must be provided to insure the minimum quantum of due process to patients.

In Parham and Institutionalized Juveniles the Supreme Court found that review by staff physicians satisfied due process. The

Court noted in Parham that the record provided "no support whatever" for the conclusion that staff physicians could not be neutral because of institutional pressures to admit children with no need for care. Id. at 2511.

The Court also held that a physician was an adequate decision-maker because

> [d]ue process has never been thought to require that the neutral and detached trier of fact be law-trained or a judicial or administrative officer....Surely, this is the case as to medical decisions for neither judges nor administrative officers are better qualified than psychiatrists to render psychiatric judgments.

Id. at 2506-07. Certainly this also applies to consideration of the four factors this court has held qualify the right of patients to refuse medication.

The Parham Court also emphasized that formal procedures are not always required:

> [D]ue process is not violated by use of informal traditional medical investigative techniques.... Not every determination by state officers can be made most effectively by use of the procedural tools of judicial or administrative decision-making....[I]t is incumbent on courts to design procedures that protect the rights of the individual without unduly burdening the legitimate efforts of the states to deal with difficult social problems.

Id. at 2507 & n.16. The court will not require a formal hearing, or even the presence of an attorney, at the mandated independent review. Any more process than an informal inquiry may cause excessive costs to the state without significantly decreasing the risk of erroneous determinations.

In determining what unconstitutional conduct can form a basis for relief, the court must also apply the principles stated in Rizzo v. Goode, 423 U.S. 362 (1976) and Lewis v. Hyland, 554 F.2d 91 (3rd Cir.), cert. denied, 434 U.S. 931 (1977). Under these cases, the court may not enjoin defendants Klein and Rotov, the relevant defendants in the two statewide subclass' right to refuse treatment claims, unless a constitutional violation is caused by their policies or deliberate indifference. Isolated incidents of improper conduct by individual psychiatrists or other staff are not sufficient to sustain

class-wide relief. Rizzo, 423 U.S. at 373-77; Lewis, 554 F.2d at 98. See also Owens v. Haas, No. 829, slip op. at 3652 (2nd Cir. July 9, 1979).

Rizzo also requires a certain equitable restraint or abstention where relief is sought against a state agency. 423 U.S. at 377-80. The court is fully cognizant of the principles of federalism stated therein, and must attempt to fashion any order such that it disrupts hospital operations as little as possible. But the court must also be vigilant to insure that plaintiffs' rights are upheld. As stated by Chief Judge Lord of the Eastern District of Pennsylvania:

> Notions of comity and the limitations placed upon the use of federal equitable power restrain federal courts from intruding into daily operation of state agencies. But federal courts also have the clear obligation to terminate conditions and actions which violate constitutional rights, particularly for those who are powerless to end such abuse.

Santiago v. City of Philadelphia, 435 F. Supp. 136, 149 (E.D. Pa. 1977).

Medicine has not yet found a cure for the terrible pain of mental illness. The law cannot assist in this endeavor. But the constitution can and does prevent those who have suffered so much at the hands of nature from being subject to further suffering at the hands of man.

## II. Inadequacies in Division Practices

While the Division has made certain commendable efforts to improve the procedures surrounding administration of drugs, the court holds that defendants' policies nevertheless fail to meet constitutional standards in a few critical areas. While there have been numerous acts by individual treating physicians and staff which are outside constitutional standards, the court must emphasize that the current policies and mandated procedures of defendants Klein and Rotov and their conscious and deliberate indifference to breaches of patients' rights by hospital personnel form the basis for relief in this action. Remedial action is not barred by Rizzo and Lewis.

The evidence has shown that defendants are contemplating certain steps which might correct some of the inadequacies found. However, defendants have refused to stipulate that procedures that have been mandated in writing will be fully implemented, much less that other measures contemplated will be carried out. Therefore the court must order certain procedures which might have become Division practices regardless of the court's action. The court is naturally reluctant to so order, but feels that this intervention is proper at this time because certain orders are required anyway and because defendants refuse to guarantee that such measures--which undoubtedly have been spurred by the litigation so far--will indeed be implemented. The rights at stake here are too important to wait on unsubstantiated promises of compliance.

The first major shortcoming in the hospitals' procedures is failure to adequately inform patients of their rights and the effects of drugs, particularly long-term side effects. While certain improvements are contemplated, the hospitals' current record reflects a total failure by defendants Klein and Rotov to insure that all patients are aware of the dangers of their medication, and know that they can reject or appeal medication decisions of their doctors.

Second, the hospitals have not sought written consent to specific administration of drugs. Such a step is apparently contemplated though there is no indication in the record when or whether it actually will be implemented. Neither have defendants made any provision for independent review of those patients who may be incapable of giving informed consent. All of these problems are sufficiently linked to the policies or deliberate indifference of defendants Klein and Rotov to justify classwide equitable relief because defendants have refused to implement informed consent procedures despite the atmosphere of coercion in the wards that makes such steps absolutely necessary for providing patients a realistic refusal right.

The court also finds improper the defendants' policy of limiting review of a physician's decision to forcibly medicate to informal hearings before the treatment team and hospital medical director.

this does not constitute the independent determination required by the due process clause, and the case is thus distinguishable from Parham. Here there are institutional pressures on treating physicians to medicate patients unnecessarily. Treatment team review is somewhat controlled by the treating physician and cannot constitute an independent determination. While the medical directors have asserted in their testimony that they are capable and willing to overrule their staff doctors when necessary, the court finds more credible the testimony of those experts who stated that the directors would inevitably be caught in a conflict between patients' interests and pressures from their staff.

The court does not impugn the good faith of the directors, who appear genuinely determined to reduce unnecessary reliance on drugs and to increase the involvement of patients in their own treatment decisions. Rather the court believes that institutional pressures--similar to the pressures that have created the unfortunate legacy of overdrugging in state mental hospitals--make it impossible for anyone in the medical director's position to have sufficient independence, much less the appearance of fairness which due process requires. In different contexts the law has required that a decision-maker be outside the state bureaucracy whose actions impinge on individuals' protected interests. See, e.g., Morrissey v. Brewer, 408 U.S. 471, 485-89 (1972) (parole revocation hearings). This is particularly important where informal procedures are allowed. As stated by Judge Friendly:

> [A]gencies might be offered an option of less procedural formality if the decisionmaker were not a member of the agency and still less if, as in England, he were not a full-time government employee at all.

Friendly, Some Kind of Hearing, 123 U. Pa. L. Rev. 1267, 1279 (1975).

While review by the medical director may be a prudent check inside the hospital structure, the court must hold that it does not meet the dictates of the law.

There is evidence that Dr. Rotov, the Division Director, or one of his assistants in the central office, are willing to review the medical directors' decisions to forcibly medicate. While this might

provide an adequately independent decision, there is no indication in the record that Dr. Rotov or his current assistants would have the time or willingness to review the significant number of cases that may be appealed once patients are fully informed of their rights. It should also be noted that the medical directors' authorizati in Bulletin 78-3 to consult an independent psychiatrist does not insure such an independent review in every case, nor are the consultant's recommendations binding on the medical record.

The court finds review by a psychiatrist, rather than a judge or administrative hearing officer, to be constitutionally adequate. Therefore, in structuring the order entered against defendants, the court will allow the independent decision-maker to be a psychiatrist, which is apparently the defendants' preference if relief must be granted on this point. Indeed, such a review would be similar to the central office review which has been proposed.

The defendants have no system for providing representation to patients who appeal the decisions of their staff psychiatrists. While the defendants have tentative plans to place a patient advocate at each hospital, there is no guarantee in the record that such a step will be taken or that representation will be assured for all who refuse.

Finally, the policies and procedures of defendants are inadequate because defendants have failed to even acknowledge and instruct their staff that involuntary patients have a qualified right to refuse.

III. Standards on a Preliminary Injunction

Four factors are considered in the application for a preliminary injunction: (1) whether the moving party has shown that it is likely to prevail on the merits, (2) whether the movant has demonstrated that he would be irreparably harmed if the preliminary injunction is denied, (3) whether the grant of the injunction would harm other interested parties to a greater extent than it would benefit movant, and (4) whether the public interest would be served. A. O. Smith Corp. v. F. T. C., 530 F.2d 515, 525 (3rd Cir. 1976).

After 17 days of hearings, the plaintiffs have clearly demonstrated a likelihood of prevailing on the merits on the re-certified classes. It is also clear if defendants are not enjoined plaintiffs will be irreparably harmed by the transient discomfort and permanent injury caused by medication. The court finds that prevention of these harms outweighs the additional administrative costs the order may impose on the state. Finally, protection of plaintiff's constitutional rights is indisputably in the public interest.

IV. Explanation of the Decree

The court has attempted to closely tailor its order in this case to the clear violations of privacy and due process engendered by the policies of defendants. The order is designed to interfere with hospital operation as little as possible while still guaranteeing a realistic opportunity for patients to exercise their qualified right to refuse treatment. The court has also tried to include in its decree those ideas discussed by defendants themselves, but never fully implemented, which, when put into full effect, would satisfy constitution requirements.

The order has five components. First is use of affirmative consent forms which must be signed by all patients before they are medicated. The court believes this is the least intrusive way to insure that involuntary and voluntary patients will have the opportunity to assert their constitutional rights despite the history of coercion and intimidation in the hospitals. The forms must contain the information on drugs and patient rights so that consents will be informed.

The second component is a system of Patient Advocates, which is essentially a full implementation of an idea which has been carried out by the Division in limited form only. See also Ex. D-18, p. 91. The Advocates are given two areas of responsibility. First, they are to analyze cases where the treating physician certifies that a patient is incapable of providing informed consent. At that time an Advocate

may act for the patient and obtain in-hospital and independent review, although medication is permitted during that time. The court notes that it would be unrealistic to rely on legal guardians to protect the rights of incompetent patients in this respect. See Tr. XXVII, 19-20.

Advocates shall also serve as informal counsel to patients who wish to refuse, and, in particular, those whose cases are reviewed by an independent decision-maker.

The court believes that the Patient Advocates will play a crucial part in upholding patients' rights. It is anticipated that these individuals will be required to withstand great pressures from hospital doctors and staff. But the patients, as well as this court, will rely on their fortitude and perseverence. The Advocates are to be appointed by the Office of the Commissioner of the Department, Ms. Klein, in order to insure their independence from the hospital bureaucracy, and it is the responsibility of the Commissioner to keep the Advocates autonomous.

The court has considered requiring defendants to obtain legal representation for patients from the Division of Mental Health Advocacy or from private attorneys paid by the state on a retainer basis. This might better insure the independence of those counseling patients. However, this could only be required if the court simply prohibited all forced medication until the state legislature appropriated additional funds to the Department of the Public Advocate or for retained counsel. The court is naturally reluctant to do this when it hopes that Commissioner Klein and her successors will insure the necessary independence and qualifications of Advocates they appoint. The court believes attorneys are not necessary here, and may even be counter-productive since many compromises between patients' expressed desires and good medical practice will need to be made. The success of this aspect of the court's decree will be closely monitored during the time before a final order is entered.

The third component of the order is requirement of informal review by an independent psychiatrist before the hospital may forcibly

medicate an involuntary patient. These psychiatrists will also be appointed by the Commissioner. The court believes a psychiatrist will be more effective in the role than a judge, lawyer or layperson, and that due process only requires an informal hearing which can readily be conducted by a medical person. In response to defendants' argument, the court notes that review of the medical director's decision to forcibly medicate by a panel of the Appellate Division of the Superior Court under N.J.Ct.R. 2:2-3(a)(2) does not meet due process. There is no evidence that such review has ever occurred, and almost certainly the scope of review would be restricted. See New Jersey Guild of Hearing Aid Dispensers v. Long, 75 N.J. 544, 384 A.2d 939 (1978); Parker v. Dornbierer, 140 N.J. Super. 185, 356 A.2d 1 (App. Div. 1976). Such review would also necessitate the appointment of independent counsel in every case.

The fourth part of the order is enforcement of voluntary patients' right to refuse treatment under state law, N.J.Stat. 30:4-24.2(d)(1).

The last component of the order is provision for forced medication in emergency situations, which, the court holds, not only qualifies the constitutional privacy right, but also the right of voluntary patients under state law. It also provides for the forced medication of patients involuntarily committed for short-term hospitalization under certain state statutes, but only in emergency situations. The court holds that the qualified privacy right is always outweighed in these emergency situations where the patient is in an acute psychotic state, has little competence but often is in great need of a psychotropic drug, and short-term use presents very little risk of permanent side effects.

The order only applies to psychotropic medication since it is the only type of drug for which there has been proof of harm to patients and overuse in the hospital.

The court has required that special reports on implementation of this decree and Department and Division orders on involuntary medication be submitted during the period before a final hearing is

held and a final order is entered. However, the court relies on the Division of Mental Health Advocacy, plaintiffs' counsel, to scrutinize the implementation of the order in this case. The court will be open to further hearings if defendants fail to comply with the decree.

Finally, the court notes that while the provision of independent review here is intended to provide an efficient method for complying with due process, it does not preclude any member of the classes from bringing a civil rights action in federal court. However, appropriate deference would be given to a decision by an independent psychiatrist to allow a hospital to forcibly medicate an involuntary patient.

STANLEY S. BROTMAN
United States District Judge

Dated: September 14, 1979

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

JOHN E. RENNIE,

Plaintiff,

v.

CAROLINE MAUGER, EUGENIO BURGOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI,

Intervenors, on behalf of themselves and all others similarly situated,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNICK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

Defendants.

Civil Action No. 77-2624

ORIGINAL FILED
SEP 14 1979
ANGELO W. LOCASCIO, CLERK

PRELIMINARY INJUNCTION

Application by the involuntary adult subclass and voluntary adult subclass of plaintiffs and intervenors for a preliminary injunction having been heard by the court; and

The court having considered the testimony, exhibits, briefs and argument of counsel; and

For the reasons stated in the court's opinion filed this day,

It is on this 14th day of September, 1979, hereby ORDERED of defendants Klein and Rotov:

A. Beginning January 7, 1980, defendants shall establish for the adult units of the Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital, Marlboro Psychiatric Hospital, Trenton Psychiatric Hospital, and Glen Gardner Geriatric Center:

1. Consent forms. A system of consent forms to be signed by patients before they are prescribed psychotropic drugs by hospital physicians

in non-emergent situations. Such consent forms shall state in plain language the right of voluntary patients to refuse treatment and the qualified right of involuntary patients to refuse and to have their refusals reviewed within the hospital, and by the independent psychiatrist as described in this order. The forms shall also state the availability of Patient Advocates to assist patients who wish to refuse treatment. Each form shall also state all known short-term and long-term side effects of the drug to be consented to, and may be supplemented by informal discussion by hospital staff with the patient concerning the risks and benefits of the drugs. A single form may be used to obtain the consent for up to three different medications, to be used concurrently or alternatively. Information on the rights of patients and the side effects of all psychotropic drugs used in a hospital shall be posted or made available on each ward.

2. Patient Advocate. The Office of the Commissioner of the Department of Human Services shall hire, pay, train and supervise an adequate number of Patient Advocates in each hospital. The Patient Advocates' duties shall include those described in this order. The Patient Advocates must be supervised by an attorney and psychiatrist in the Office of the Commissioner. The Advocates may be trained attorneys, psychologists, social workers, registered nurses or paralegals, or have any equivalent experience. They must be given training in the effects of psychotropic medication and the principles of legal advocacy.

3. Independent Psychiatrist. The Office of the Commissioner shall hire and pay psychiatrists to review the decisions to forcibly medicate involuntary patients.

B. Beginning January 7, 1980, no voluntary or involuntary patient age 18 years or older in the five hospitals may be given any drug commonly labelled "psychotropic" by the medical profession unless the patient has signed a consent form pertaining to the specific drug. The written consent shall apply indefinitely subject to the other conditions of this order. No voluntary or involuntary patient may be given psychotropic medication if he states to a doctor or nurse

that he does not want the specific drug. An injection of psychotropic medication may not be based on a prior written consent if the patient orally refuses at the time of the injection. Patient Advocates may consult with any patient and assist him in refusing medication orally. An Advocate can also require that the hospital obtain renewed written consent if a patient who has previously given written consent has since orally refused. The medical director, any treating physician or other member of the hospital staff may encourage a patient to consent to and take medication; however, force or the threat of force may not be used unless forced medication is allowed for a patient under the terms of this order.

C. Medication may be given orally or by injection without written consent and despite oral refusals in the following circumstances:

1. Emergency Situation. Where the treating psychiatrist certifies in a voluntary or involuntary patient's record that there is an emergency situation. An emergency is a sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital. Medication may then be forcibly administered for 72 hours. Certification by the medical director of the hospital may extend that period for 72 more hours if the threat to life or limb continues. Any person who is temporarily committed to a mental hospital or other institution pursuant to the procedures provided by the temporary commitment provisions of the New Jersey statutes[1] may be involuntarily medicated only if his condition constitut an emergency situation as defined above, and any person who is involuntarily held in a mental hospital or institution but who has not been permanently or temporarily committed in accordance with the procedures mandated by the applicable New Jersey statutes may not be medicated against his will under any circumstances.

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1. N.J.Stat. Ann. 30:4-46.1 (seven day temporary commitment for observation); N.J.Stat. Ann. 30:4-26.3 (15 day temporary commitment for observation, examination, and treatment); and N.J.Stat. Ann. 30:4-37 and 4-38 (twenty day temporary commitment).

2. Legally incompetent patient. An involuntary patient declared legally incompetent may be medicated without written consent if proper consent is obtained in accordance with state law. However, decisions to medicate legally incompetent patients must also be referred to a Patient Advocate who may at any time assess the patient's feelings about the drug, side effects, failure to consistently take the medication and the use of force or threat of force by hospital staff to administer the drug. The Patient Advocate may then, in his discretion initiate review under Administrative Bulletin 78-3, or similar hospital procedures succeeding that Bulletin, and may, in his discretion, seek review to the Independent Psychiatrist. The patient's guardian must be notified. Medication shall be permitted during the time period for review, which shall not exceed 15 days. A Patient Advocate shall review the treatment regime of each incompetent patient at least once every three months.

3. Functionally incompetent. A treating physician may certify in an involuntary patient's record that the patient is "functionally incompetent" because he is unable to provide knowledgeable consent to treatment, although he has not been declared incompetent by a court of law. These cases must also be referred to the Patient Advocate who shall review the case and initiate review in the manner described above for legally incompetent patients.

D. Except as provided in Paragraph C(1) of this order, no voluntary patient may be medicated who does not sign a consent form or who orally refuses.

E. Except as provided in Paragraphs C(1) through (4) of this order, where an involuntary patient refuses to provide consent after all in-hospital procedures are exhausted, or where an involuntary patient refuses intermittently and the hospital seeks to give medication on a continuous basis, the hospital may seek permission to involuntarily medicate by bringing the patient before the Independent Psychiatrist, in accordance with the following guidelines (the same guidelines shall

apply to hearings brought by a Patient Advocate under Paragraphs C(3) and (4) of this order):

1. Notice. The patient must have at least five days between the first refusal to a staff nurse or physician and presentation to the Independent Psychiatrist.

2. Advocate. The patient shall be allowed to have an attorney and Independent Psychiatrist present at this hearing. However, the state need only supply a Patient Advocate if the patient cannot or does not wish to have his own private counsel. The Patient Advocates at each hospital shall be notified of all refusals reaching the Medical Director under Bulletin 78-3 so that an Advocate can prepare any cases appealed to the Independent Psychiatrist.

3. Hearing. The Independent Psychiatrist may hold an informal proceeding. All hospital records should be made available to the Independent Psychiatrist, and he may conduct a medical examination of the patient where necessary. No compulsory access to witnesses or cross-examination need be permitted, although the Independent Psychiatrist may request hospital employees to appear if he deems this necessary.

4. Opinion. The Independent Psychiatrist shall issue a written determination in each case, basing any decision to override the patient's privacy right on the four factors outlined in the court's November opinion. He may also consider whether the use of the drugs in a particular case violates the principles of the first and eighth amendments as discussed in the November opinion. 462 F. Supp. at 1143-44. He may "settle" the dispute by obtaining consent to treatment from the patient, or he may remand the case to the hospital medical director or treating physician for reformulation of a treatment plan in accordance with specific directives. He may prohibit use of psychotropic drugs altogether if required by the patient's preferences and his qualified right.

5. Effective Period. The Independent Psychiatrist may state a time period for which his decision allowing the hospital to forcibly medicate remains effective. This period should not exceed 60 days,

and should preclude a patient from seeking review by the Independent Psychiatrist during that time. However, review may be had if the patient contends the hospital has failed to adhere to the Independent Psychiatrist's decision concerning proper treatment. The hospital may seek a rehearing in any case at any time.

F. In order to assist the court's consideration of the relief at the final hearing on the issues presented, defendants are ordered to submit monthly reports describing in reasonable detail their implementation of Administrative Order 2:13, Administrative Bulletins 78-3 and 78-6, and any other subsequent mandates on administration of psychotropic drugs, as well as their implementation of this order. The first report, covering the month of September 1979, shall be submitted on or before October 15, 1979, and each report shall be due by the 15th of the month thereafter during the period before a final order is entered.

G. Where this order specifically refers to voluntary patients, the order grants relief for that subclass, and where it specifically refers to involuntary patients it grants relief for that subclass. Where neither category is referenced, then relief is granted for both subclasses.

No preliminary injunction shall issue against defendants Pepernik, Wallis, Balita, Santos, Ivanov and Abraham.

No costs are awarded.

STANLEY S. BROTMAN
United States District Judge



38d

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

JOHN E. RENNIE, : Civil Action No. 77-2624

Plaintiff, :

CAROLINE HAUGER, EUGENIO BURGOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARAGRET MARY MC GRATH, JOSEPH KAMIENSKI, :

Intervenors, on behalf of themselves and all others similarly situated, :

v. :

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNICK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital, :

Defendants. :

FILED
DEC 21 1979
At 8:30
ANGELO W. LOCASCIO
Clerk

O P I N I O N

APPEARANCES:

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Appendix E. 12

BROTMAN, District Judge

This is a motion to stay the enforcement of the court's order of September 14, 1979 in the above-captioned case, reported at 476 F. Supp. 1294 (D. N.J. 1979), pending appeal of the court's decision to the Court of Appeals for the Third Circuit. This court is authorized to hear this motion by Fed. R. Civ. P. 62(c), and a party is normally required to apply to the district court first before he may apply to the court of appeals or an individual circuit judge for a stay pending appeal. Fed. R. App. P. 8(a).

This case has a long history, which is amply discussed in the court's prior opinions, 476 F. Supp. 1294 (1979) and 462 F. Supp. 1131 (1978). Therefore, instead of restating the entire procedural history of this case, the court will focus upon the facts relevant to this particular motion.

On July 13, 1979, plaintiff and intervenors filed a motion for a preliminary injunction against the defendants. The court held hearings on this motion for several days, concluding them on August 9, 1979. Before issuing its ruling on the motion for a preliminary injunction, the court advised the litigants of its intended action and sought their comments on its proposed order. It explained the considerations which shaped the order in its September 14, 1979 opinion:

> The court has attempted to closely tailor its order in this case to the clear violations of privacy and due process engendered by the policies of defendants. The order is designed to interfere with hospital operation as little as possible while still guaranteeing a realistic opportunity for patients to exercise their qualified right to refuse treatment. The court has also tried to include in its decree those ideas discussed by defendants themselves, but never fully implemented, which, when put into full effect, would satisfy constitutional requirements.

476 F. Supp., at 1311. The court made its preliminary injunction decree effective January 7, 1980, with the exception of Part F, which mandates the submission of monthly reports by the defendants on the implementation of the court's order, as well as certain administrative guidelines. The defendants have complied with the reporting requirements of the court's order, and these reports have

documented the extent of their implementation of the rest of the order. The court has carefully reviewed and relied upon these materials in considering the defendants' current motion.

In its September 14, 1979 opinion, the court made the following analysis of the merits of the motion for a preliminary injunction:

> Four factors are considered in the application for a preliminary injunction: (1) whether the moving party has shown that it is likely to prevail on the merits, (2) whether the movant has demonstrated that he would be irreparable harmed if the preliminary injunction is denied, (3) whether the grant of the injunction would harm other interested parties to a greater extent than it would benefit movant, and (4) whether the public interest would be served. A. O. Smith Corp. v. F.T.C., 530 F.2d 515, 525 (3rd Cir. 1976).
>
> After 17 days of hearings, the plaintiffs have clearly demonstrated a likelihood of prevailing on the merits on the recertified classes. It is also clear that if defendants are not enjoined plaintiffs will be irreparably harmed by the transient discomfort and permanent injury caused by medication. The court finds that prevention of these harms outweighs the additional administrative costs the order may impose on the state. Finally, protection of plaintiff's constitutional rights is indisputably in the public interest.

Id.

The defendants' present motion asks this court to evaluate similar factors in determining whether to stay the enforcement of the order pending appeal. An application for a stay pending appeal is governed by Fed. R. Civ. P. 62(c), which provides in pertinent part:

> When an appeal is taken from an interlocutory or final judgment granting, dissolving, or denying an injunction, the court in its discretion may suspend, modify, restore, or grant an injunction during the pendency of the appeal upon such terms... as it considers proper for the security of the rights of the adverse party.

The court's resolution of a Rule 62(c) motion is guided by four basic factors. Although different courts have not used completely identical language, they have agreed upon the list of factors, which were recently described by a district court in this circuit in Evans v. Buchanan, 435 F. Supp. 832, 841 (D. Del. 1977):

> A motion for a stay is addressed to the sound discretion of the Court. Coppedge v. Franklin County Board of Education, 293 F. Supp. 356, 362 (E.D. N.C. 1968). The burden of [the moving parties]

> is to show: (1) a showing that they will suffer irreparable injury if the stay is denied; (2) a strong showing they likely will succeed on the merits of their appeal; (3) a showing the plaintiffs will not be substantially harmed by the stay; and (4) a showing no harm will be done to the public interest. Reserve Mining Co. v. United States, 498 F.2d 1073, 1076-1077 (8th Cir.), application to vacate stay denied, 419 U.S. 802, 95 S.Ct. 287, 42 L.Ed.2d 33 (1974).

In view of the similarity of the standards governing decisions to issue preliminary injunctions and to stay their enforcement pending appeal, the defendants' motion to stay pending appeal seems to be defective in certain crucial respects. The court will now examine these potential deficiencies.

First, the court notes that in ruling upon the motion for a preliminary injunction it concluded that the moving parties "have clearly demonstrated a likelihood of prevailing on the merits." Rennie, 476 F. Supp., at 1311. This appears to be inconsistent with the requirement that the court staying enforcement of an injunction conclude that the moving party is likely to prevail on the merits.

The defendants have responded to this argument by asserting that the concept "likely to prevail" has a different meaning in the two different contexts, and have cited two cases in support of their claim that they are likely to prevail as that term is applied to motions for stays pending appeal. The first case cited by the defendants is Evans v. Buchanan, 435 F. Supp. 832 (D. Del. 1977), which involved a motion to stay the district court's proceedings in school desegregation cases pending a decision by the United States Supreme Court upon the movant's petition for a writ of certiorari. Although the court in Evans did suggest that a more liberal standard governs motions for stay pending appeal than that applied to motions for a preliminary injunction, its implication that the court may apply a more liberal test of the moving party's probability of success was tied to the strength of the other factors in his case, and the court noted that the ultimate determination of whether these were sufficient to overcome the relative weakness of the movant's position on the likelihood of success was a matter for the court in the exercise of its discretion. The court said:

> In a case where the movant will suffer irreparable injury in the absence of a stay, consideration of

> the merits of the movant's appeal permits an evaluation of whether that injury is likely to occur in any event. It seems illogical, however, to require that the court in effect conclude that its original decision in the matter was wrong before a stay can be issued. Rather, a stay may be appropriate in a case where the threat of irreparable injury to the applicant is immediate and substantial, the appeal raises serious and difficult questions of law in an area where the law is somewhat unclear and the interests of the other parties and the public are not harmed substantially. This is not to say, however, that every time a case presents difficult questions of law a stay should be entered. As noted earlier, the four factors must be viewed together and the interest of the movant balanced against the interest of the other parties and the public. It is the duty of the court to exercise its discretion so that an equitable resolution is achieved.

435 F. Supp., at 844. The other case cited by the defendants, Washington Metropolitan Area Transit Commission v. Holiday Tours, Inc., 559 F.2d 841, 843 (D.C. Cir. 1977) took a similar all-the-factors test. The court said:

> we hold that...a court, when confronted with a case in which the other three factors strongly favor interim relief may exercise its discretion to grant a stay if the movant has made a substantial case on the merits. The court is not required to find that ultimate success by the movant is a mathematical probability, and indeed, as in this case, may grant a stay even though its own approach may be contrary to movant's view of the merits. The necessary "level" of possibility of success will vary according to the court's assessment of the other factors.

However, it is the conclusion of this court that even if the more liberal test of likelihood of prevailing on the merits applied to the defendants' motion in this case, it would not warrant, in the exercise of the court's discretion, the issuance of a stay pending appeal. This may be seen in the observation of the court of appeals in Washington Metropolitan Area Transit Commission:

> What is fairly contemplated is that tribunals may properly stay their own orders when they have ruled on an admittedly difficult legal question and when the equities of the case suggest that the status quo should be maintained.

559 F.2d, at 844-45. The court of appeals described the appropriate situation for an order maintaining the status quo as one in which

> a serious legal question is presented, when little if any harm will befall other interested persons or the public and when denial of the order would inflict irreparable injury on the movant. There is substantial equity, and need for judicial protection, whether or not movant has shown a mathematical probability of

success

Id., at 814. The case now before this court does not fall within that description since, as the court concluded in its September 14, 1979 opinion, "[i]t is...clear if defendants are not enjoined plaintiffs will be irreparably harmed by the transient discomfort and permanent injury caused by medication." 476 F. Supp., at 1311. The court expressly noted in its November 9, 1978 opinion that the use of psychotropic drugs "cause dysfunctions of the central nervous system called extrapyramidal symptoms, as well as other side effects," 462 F. Supp., at 1137-38, including the permanent side effect of tardive dyskinesia, and, in rare cases, sudden death. Id. at 1138. Therefore, a decision to stay the enforcement of the court's preliminary injunction would unavoidably inflict significant and, to some extent, irreparable injury on the classes of persons who are to be protected by the court's order.

On the other side of the equation, the defendants have also failed to show that they would suffer irreparable injury if the court's order was not stayed pending appeal. The defendants rely upon the affidavit of Ms. Ann Klein, the Commissioner of the New Jersey Department of Human Services and one of the named defendants in this case. She avers:

> Because of...budgetary constraints, coupled with the time required to recruit, process in accordance with Department of Civil Service rules and regulations, and train new personnel, the only way the Department of Human Services could comply with the order would be by shifting existing Department or Division of Mental Health and Hospitals personnel and resources from their current spending plan to meet the requirements of the preliminary injunction. These staff will then be unable to perform their ordinary duties which are of critical importance to the operation of the State psychiatric hospitals. On the other hand, if a stay was granted and the judgment of this court affirmed, the Department of Human Services would be able to take the necessary time to recruit, hire and train personnel whose sole function would be to comply with the provisions of the preliminary injunction.

Defendants' Brief, Appendix A, at 2. However, Ms. Klein's statement overlooks two key points. First of all, she neglects to mention that in the three months since the court issued its order on September 14, 1979, she has taken no action to obtain additional funds to cover the

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costs of implementing the court's decision. Instead she has stated that the only way in which the defendants can comply with the court's order is to totally eliminate the Department of Human Services client advocate program, at the cost of terminating important services rendered to patients in the state's mental institutions. The court does not believe that this proposed course of action exhausts the means of generating sufficient resources to implement the court's order, especially in view of the fact that the defendants have not actively considered any alternatives. Under such circumstances, the court is guided by the statement in Long v. Robinson, 432 F.2d 977 (4th Cir. 1970), in which Judge Winter of the Fourth Circuit was called upon to issue a stay of a district court order pending appeal. In that case, the district court had

> declared unconstitutional certain provisions of the Ann. Code of Md., Art. 26, § 51 et seq., and the Charter and Public Local Laws of Baltimore City, Art. 4, § 240, which exempt Baltimore City from the uniform state definition of juvenile age as 18 years. By virtue of these statutes a child in Baltimore City ceases to be a juvenile upon obtaining the age of 16. The age for determining who is a juvenile is important, because juveniles are treated differently from adults when they are charged with a violation of the criminal laws and for other purposes. The order required that all persons between 16 and 18 years of age when arrested (except in the case of alleged capital offenders) who are currently confined in the city jail and other places of incarceration in Baltimore City awaiting trial be released to the juvenile authorities "as expeditiously as possible."

Id., at 978. In considering the allegations of irreparable injury to the moving party if the motion for a stay pending appeal was not granted the court commented:

> I do not minimize the cost, the inconvenience or the burdens which will be placed upon the defendants should they begin compliance with the order. However, "[m]ere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough." Virginia Petroleum Jobbers Association v. Federal Power Commission, 259 F.2d at 925.

Id., at 980. Judge Winter later added:

> Regrettably I must conclude that the principal irreparable injury which defendants claim that they will suffer if the order of the district court is not stayed is injury of their own making. The defendant State of Maryland has postponed the moment of truth as long as possible, but the moment of truth is now at hand. It would seem elementary that a party

may not claim equity in his own defaults.

Id. Similarly, the defendants cannot rely upon their alleged economic difficulties when they have not sought additional funds which would relieve, or at least reduce, the budgetary strain which they may be experiencing and thereby permit them to comply with the court's order with a minimum of disruption. The second point which Ms. Klein fails to adequately address in her affidavit is the reason for the defendants' request for a stay of the court's preliminary injunction. Ms. Klein refers to the administrative difficulties posed by the order's January 7, 1980 deadline and claims that a stay would "permit the Department of Human Services to more adequately comply with the injunction... without at the present time causing a substantial disruption of other essential services to State psychiatric hospital patients." However, the defendants have asked for a stay based upon the time needed to appeal this court's decision, not the time needed for the optimal implementation of the court's order. This significantly undermines the defendants' assertion that a stay is necessary to prevent the premature implementation of the court's order and the unnecessary disruption of the system for the delivery of health care to patients in the New Jersey psychiatric institutions. Moreover, if the defendants were sufficiently alarmed by any problems which may have been created by the court's January 7, 1980 deadline, they should have promptly raised these concerns with the court after it issued its September 14, 1979 order. They should not have waited until now to request a stay. Their tardiness in raising these administrative concerns, when viewed in conjunction with their failure to seek additional funds to underwrite the costs of implementing the court's preliminary injunction, undercuts their allegations of irreparable injuries which would justify a decision to stay this court's prior order.

In view of the foregoing analysis, the court must conclude that the defendants have not satisfied their burden of proving that they are entitled to a stay of the court's order pending the disposition of their appeal to the court of appeals. However, defendants have made an additional request which is relevant to the court's consideration of the motion for a stay of its order. They have asked that if this

court does deny their motion for a stay pending appeal of its preliminary injunction order of September 14, 1979, that the court at least stay the order long enough to permit its decision on the motion to stay to be reviewed by the court of appeals or a circuit judge. The court has been advised by counsel for defendants that counsel for the plaintiff and intervenors has consented to a delay in the implementation of this court's preliminary injunction order from January 7, 1980 to January 21, 1980. The court believes that the defendants' request for a short postponement of the implementation of the court's order is reasonable, and the parties' agreement is a just compromise which should minimize the burden imposed upon any party by the appellate process. Therefore, the court will grant the defendants' request to delay the implementation of the court's order, with the exception of the reporting requirements of Part F, until January 21, 1980.

To sum up, the court will deny the defendants' motion for a stay in the enforcement of the court's preliminary injunction order of September 14, 1979, but it will grant the defendants' request to stay the implementation of the court's order until January 21, 1980, with the exception of Part F, which remains in effect.

The court will file an appropriate order.

STANLEY F. BROTMAN
United States District Judge

Dated: December 21, 1979

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

| | | |
|---|---|---|
| JOHN E. RENNIE, | : | Civil Action No. 77-2624 |
| Plaintiff, | : | |
| CAROLINE MAUGER, EUGENIO BURGOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELMER, MARY JANE WEISS, MARAGRET MARY MC GRATH, JOSEPH KAMIENSKI, | : | |
| Intervenors, on behalf of themselves and all others similarly situated, | : | |
| v. | : | FILED<br>DEC 21 1979<br>At 8:30 M.<br>ANGELO W. LOCASCIO<br>Clerk |
| ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNICK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital, | : | ORDER DENYING STAY |
| Defendants. | : | |

This matter having been brought before the court on the 21st day of December, 1979; and

The court having considered the briefs, correspondence, and material provided by the defendants pursuant to the court's preliminary injunction order of September 14, 1979; and

For the reasons stated in the court's opinion filed this day,

It is on this 21st day of December, 1979, hereby ORDERED that defendants' motion for a stay of the court's September 14, 1979 order in the above-captioned case is hereby denied. The court will change the date for the implementation of Parts A-E and Part G of its September 14, 1979 order from January 7, 1980 to January 21, 1980. Part F of the court's order of that date shall remain in effect.

No costs.

STANLEY S. BROTMAN
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

| | | |
|---|---|---|
| JOHN E. RENNIE, | : | Civil Action No. 77-2624 |
| Plaintiff, | : | |
| v. | : | |
| ANN KLEIN, etc., et al., | : | |
| Defendants. | : | O P I N I O N |

APPEARANCES:

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Attorneys for Defendants

ORIGINAL FILED
NOV 9 1978
ANGELO W. LOCASCIO, CLERK

This matter is before the court on the motion of plaintiff, John E. Rennie, for a preliminary injunction pursuant to Fed. R. Civ. P. 65. Plaintiff is an involuntary patient of Ancora Psychiatric Hospital, a state institution. He seeks to enjoin the defendant psychiatrists and officials at Ancora from forcibly administering drugs to him in the absence of an emergency situation. The complaint is grounded on 42 U.S.C. § 1983, with jurisdiction pursuant to 23 U.S.C. § 1343. The following are the court's findings of fact and conclusions of law, Fed. R. Civ. P. 52.

## FINDINGS OF FACT

### I. Procedural History

The complaint in this action was filed on December 22, 1977. While the complaint is stated in six counts, plaintiff essentially charged defendants with violations of four rights: (1) the right to refuse medication in non-emergent circumstances, (2) the right to treatment, (3) the right of access to counsel, and (4) the right to be free from physical abuse while in custody.

On the same date, counsel for Mr. Rennie, Sheldon A. Gelman of the New Jersey Public Advocate's Office, and counsel for the state officials, Steven D. Wallach, Deputy Attorney General, appeared in chambers on an application for a temporary restraining order. The parties agreed that only the issue of the right to refuse medication would be considered on the motion for a preliminary injunction. In an order prepared that day and filed December 30th, it was ordered that plaintiff not be medicated against his will beyond a maintenance dosage except in emergencies. Counsel agreed, after consultation with the state psychiatrists, that a maintenance dosage would be 15 mg. of prolixin hydrochloride per day. Dr. Marvin Greenberg, plaintiff's expert, was named temporary consultant to the court.

On January 13, 1978, hearings on the motion for preliminary injunction began. The court conducted fourteen days of hearings; the final day was April 28, 1978. Testimony was taken from hospital

officials and employees; three Ancora psychiatrists, Dr. Botov, Director of the state Division of Mental Health and Hospitals, three psychiatrists from outside the state system produced by plaintiff, and two outside psychiatrists produced by defendant.[1] Counsel were then allowed to prepare proposed findings and briefs.

During the lengthy course of these hearings, plaintiff attempted suicide by swallowing an overdose of pills on April 10, 1978. Transcript, Volume X, page 5, April 12, 1978 (hereafter cited in the form Tr.X, 5, 4/12/78). Defendants moved to remove the temporary restraining order on April 12. Instead, the court reserved decision and requested that all doctors involved in Mr. Rennie's case convene on April 14 to attempt to reach a consensus on the future course of plaintiff's treatment. The psychiatrists agreed that plaintiff should be treated immediately with an antidepressant medication, followed by the use of lithium carbonate when his depression lifted. There was disagreement over when an antipsychotic drug should be used. On the representation that the lithium - antidepressant regime would be commenced and that plaintiff consented thereto, the temporary restraining order was dissolved by order dated April 18, 1978.

It should be noted that on April 12, Dr. Max Pepernik, Medical Director of Ancora, had stated that if any antipsychotic medication (these drugs are also called "psychotropics") were resumed as treatment, it would not be prolixin because of plaintiff's aversion to that drug. Tr. X, 14. Based on the hearings, the court certainly agrees that this is appropriate. However, much of the court hearing was devoted to examining studies of this particular drug. Defendants argue that, to the extent plaintiff seeks to

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1. Drs. Greenberg, Pepper, and Limoges were called by plaintiff. Drs. Stinnett and Heller were the state's two outside consultants.

enjoin the use of prolixin, this case is moot since defendants are not now using that drug and have indicated no plans to do so. Defendants' Proposed Findings of Fact, No. 23, June 23, 1978.

On May 19, 1978, plaintiff brought the parties before this court seeking to restrain the hospital's use of thorazine, another psychotropic drug. Since the April 28 hearing, it was reported that the hospital gave Mr. Rennie every possible chance on li but that he was dangerous to himself, other patients, and the staff. After placing Mr. Rennie in restraints for three days, the decision was made to medicate him with thorazine. Relief was denied plaintiff pending briefing by the parties and the issuance of this opinion, unless plaintiff was prepared to put forward further medical testimony Thus, while the issue as to prolixin may be moot, defendants have used other drugs of the same type since April. Since the testimony indicat that the benefits and detrimental side effects of all psychotropic drugs are similar, the case as a whole is not moot.

II. The plaintiff's Personal History

John Rennie is a highly intelligent[2] 38 year old white divorced male. Before his psychiatric difficulties began, he worked as a pilot and a flight instructor. His first symptoms of mental illness appeared in December 1971. Def. Exh. 2, Case History. Serious problems commenced early in 1973, in the wake of his twin brother's death in an airplane accident.

His medical history is lengthy and can only be highlighted here. His first admission to Ancora Psychiatric Hospital was o April 1, 1973. He was depressed and suicidal, and diagnosed as a paranoid schizophrenic. Mellaril, an antipsychotic drug, was given,

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2. Testimony of Dr. Marvin Heller, Tr. XIII, 23, 4/25/78. No dulling of the intellect or reduction in IQ has appeared throughou the course of his psychiatric difficulties. Testimony of Dr. Marvin Greenberg, Tr. I, 77, 1/13/78.

and plaintiff was released on April 5 to the Fairmont Farms Hospital, a private facility. Def. Exh. 2; Testimony of Dr. Ortanez, Tr. II, 100, 1/19/78.

There followed a revolving door series of readmissions and releases. His second admission was from May 2, 1973 to June 1, 1973, with plaintiff exhibiting similar suicidal ideas and religious delusions. By his third admission, from February 18 to February 26, 1974, he began to exhibit some aggressive and abusive symptoms. Thorazine, another antipsychotic drug, was used. Delusions that he was Christ continued in the fourth admission in March 1974. Tr. II, 102-04

Subsequent admissions showed further trials of different medicines. During the sixth admission, from April 9 to May 7, 1974 on a voluntary commitment, there is the first indication of a refusal to take medication. He was discharged against medical advice. His eighth admission, on a voluntary commitment from August 26 to September 10, 1974, was initiated when the Secret Service brought him to state authorities after he threatened to kill President Ford. His behavior again was abusive and assaultive. This type of assaultive behavior continued during his ninth admission from September 18 to October 12, 1974, so that the hospital placed him on homicidal precautions. Def. Exh. 2; Testimony of Dr. Ortanez, Tr. II, 100-04. He was also on homicidal precautions during his tenth admission in January 1975. His eleventh admission was involuntary and lengthy, from November 16, 1975 to June 9, 1976. His behavior was erratic, alternating between being depressed and suicidal to manic and homocidal. There was a suicide attempt on December 14 by an overdose of Mellaril. Ortanez, Tr. II, p. 37-38. Both psychotropic drugs, such as haldol, mellaril and prolixin decanoate, as well as lithium, were utilized. During this hospitalization, his diagnosis for a time was changed to manic depressive illness. Def. Exh. 2.

Throughout this period, plaintiff was inconsistent in his attitude toward the various medications, refusing at times and cooperating at others. Ortanez, Tr. III, 101. One of many causes

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of his repeated discharges and readmissions for his failure to continue taking medications after he has left the hospital's custody.

Plaintiff's twelfth and present admission to Ancora began on August 10, 1976, pursuant to an involuntary commitment. N.J.S.A. 30:4-27. Although committed, he has never been declared incompetent. See N.J.S.A. 30:4-24.2(c). The admitting diagnosis was manic depressive illness, circular type. He was placed on lithium and on suicidal and homicidal precautions. Later psychotropic drugs were added. Again, at various times, medication was refused. In December 1976, the Public Advocate's Office became involved in Mr. Rennie's case. After conversation with Mr. Gelman, the hospital agreed that medication would not be forced against the patient's will. Following an injection of prolixin decanoate on January 5, 1977, plaintiff became extremely psychotic and threatened suicide. During 1977, plaintiff was shifted between a number of medications, including thorazine, prolixin, etrafon, haldol, elavil, and lithium. Frequent incidents of fights with other patients and attendants were reported. Suicidal and delusional periods were also reported.

One particular incident prior to the commencement of this lawsuit should be noted. On November 17, 1977, plaintiff reported that evening shift attendants beat him with sticks while he was tied to a bed. The next day he pointed out the sticks, which were hidden at the nurses' station. Tr. IX, 7, 4/12/78. The investigation that followed resulted in the suspension of one employee for three days. Plaintiff and the attendant remained together in the same ward. Tr. IX, 45; Tr. II, 81.

In brief fashion, this summarizes plaintiff's history to December 1977, when this suit was commenced. The events of that month will be discussed further, infra.

III. Ancora Psychiatric Hospital

Ancora Psychiatric Hospital is a state facility for the mentally ill in Hammonton, New Jersey. It has been accredited by the Joint Commission on Accreditation of Hospitals. Dr. Ortanez and



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Dr. Bugnoan were plaintiff's treating psychiatrists during the time relevant to this litigation.

During most of his current admission, plaintiff has been housed in a barren, bleak ward; it has been described as more like a prison than a hospital. Greenberg, Tr. I, 46-7. Plaintiff sometimes has difficulty obtaining a pillow for his bed. His days contain long blocks of unproductive and unstructured time. Testimony of John Rennie, Tr. XIV, 165-67, 4/28/78. In general, doctors at Ancora do not have sufficient time for each patient. Testimony of Dr. Josefina Bugnoan, Tr. V, 61-63, 1/17/78. However, as a result of this lawsuit, the doctors are spending more time with Mr. Rennie. Tr. V, 64-65.

IV. The Medication

A. Benefits of Psychotropic Drugs

Prolixin or Fluphenazine belongs to a group of chemicals variously described as antipsychotic or psychotropic drugs. It comes in long-acting (prolixin decanoate) and short-acting (prolixin hydrochloride) form. Prolixin Decanoate is the only psychotropic drug to come in a form that will last approximately two weeks. Bugnoan, Tr. IV, 124, 1/16/78; Zander, Prolixin Decanoate: A Review of the Research, in 2 Mental Disability L. Rep. 37 (1977).

Many other major tranquilizers exist which are very similar to prolixin hydrochloride, both in therapeutic action and side effect. Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 Nw.U. L.Rev. 461, 475 (1977). These include thorazine, mellaril, haldol and trilafon. There is no evidence supporting the superiority of any one of these drugs. Bozzuto, Use of antipsychotic agents for schizophrenia, 1977 Drug Therapy 40.

In the past twenty years, psychotropic drugs have played an increasingly important role in the treatment of mental illness, and are now widely used. Psychotropic drugs tend to shorten hospital stays and allow patients to function in the community. Many consider use of these drugs necessary in any treatment program, especially

for schizophrenics. Winick, Psychotropic Medication and Competence to Stand Trial, 1977 Am. B. Found. Res.J., 769, 773-74; Zander, supra. Dr. Stinnett went so far as to testify that the failure to treat an acutely psychotic patient with drugs would be malpractice Tr. XI, 85; see also, Tr. II, 145 (quoting a 1976 National Institute of Mental Health report); cf. Whitree v. State, 290 N.Y.S.2d 486, 501, 56 Misc. 2d 693 (1968); Mason v. Superintendant of the Bridgewater State Hospital, 233 N.E.2d 908, 910, 353 Mass. 801 (1968).

More studies exist demonstrating the efficacy of the psychotropic drugs in the treatment of schizophrenia than for any other mode of treatment. DuBose, Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?, 60 Minn. L.Rev. 1149, 1167 (1976). Defendants offered a number of studies establishing the efficacy of prolixin in the treatment of schizophrenics. May, et al., Schizophrenia-A Follow-up Study of Results of Treatment, 33 Arch. Gen'l Psychiatry, 474,474-78, 481-86 (1976); Renzuto, supra at 44; E. Spohn, et al., Phenothiazine Effects on Psychological and Psycophysiological Dysfunction in Chronic Schizophrenics, 34 Arch. Gen'l Psychiatry 633 (1977). See also Zander, supra.

Of course, the research is not conslusive. Double blind testing is difficult because a placebo group will not experience the usual side effects. Thus the patient and the testers may know that he is unmedicated. Also no studies can conclusively compare the pain of schizophrenic mental states and physical side effects of medication simply because both are subjective experiences. Zander, supra at 41; Stinnett, Tr. XI, 81. Furthermore, new studies raise questions about recidivism and the efficacy of using psychotropic medication in every case. Gunderson, Drugs and Psychosocial Treatment of Schizophrenia Revisited, Dec. 1977 Psychiatry Digest 25; Simpson, et al., Psychotic Exacerbation Produced by Neuroleptics, 37 Diseases of the Nervous System 367 (1976). Patients do react idosyncratically to any particular psychotropic drug. Plotkin, supra at 475.

However, a court can appropriately make certain generalizations even at this stage of scientific knowledge. Psychotropic drugs are effective in reducing thought disorder in a majority of schizophrenics. With first admission patients, success rates of as high as 95% have been obtained. See May, supra; DuBose, supra at 1176. Success rates are less impressive with chronic patients. DuBose, supra at 1173. However, no other treatment modality has achieved equal success in the treatment of schizophrenics. Cf. Bugaoan, Tr. IX, 153-54 (quoting from Hollister, Choice of Antipsychotic Drugs, 127 Amer. J. Psychiatry 104, 104 (1970)).

Furthermore, psychotropic drugs are required in order for some patients to effectively participate in and benefit from other types of therapy, such as individual or group psychotherapy and occupational therapy. Comment, Forced Drug Medication of Involuntarily Committed Mental Patients, 20 St. Louis U. L.J. 100, 112 (1975); Wirick, supra at 781; Ortanez, Tr. III, 92; Testimony of Dr. Max Pepernik, Tr. VII, 29, 2/24/78.

In sum, psychotropic drugs are widely accepted in present psychiatric practice. A. Brooks, Law, Psychiatry and the Mental Health System 878 (1974). They are the treatment of choice for schizophrenics today. Cf. Testimony of Dr. Bertram Pepper, Tr. VIII, 32, 3/27/78; Pepernik, Tr. VII, 16.

B. Side Effects of Psychotropic Drugs

Unfortunately, all of the psychotropic drugs cause disfunctions of the central nervous system called extrapyramidal symptoms, as well as other side effects. All these vary among individuals. Zander, supra at 39. On the average, among all patients, no one drug is much worse than the others at any given therapeutic dosage.[3]

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3. Long-acting prolixin may be worse than the short-acting medications. Zander, supra at 39. However, as prolixin has been eliminated as the drug of choice, the court will not focus on this distinction.

A number of short term autonomic side effects have commonly been reported. These include blurred vision, dry mouth and throat, constipation or diarrhea, palpitations, skin rashes, low blood pressure, faintness and fatigue. Winick, supra at 782 n.66; Plotkin, supra at 476; DuBose, supra at 1203; Bugaosn, Tr. V, 84. These side effects tend to diminish after a few weeks. Ortanez, Tr. II, 139; Pepernik, Tr. VII, 23. Sudden death may also be a side effect in rare cases. Stinnett, Tr. XI, 50; Pepper, VIII, 24.

Among the extrapyramidal side effects, the two most common are akinesia and akathesia. Akinesia refers to a state of diminished spontaneity, and feeling of weakness and muscle fatigue. Zander, supra; Rifkin, et al., Fluphenazine Decanoate, Oral Fluphenazine, and Placebo in Treatment of Remitted Schizophrenics, 34 Arch. Gen'l Psychiatry, 1215, 1216 (1977). Patients with severe cases of akinesia had to be dropped from the Rifkin study of prolixin. Akathesia is a subjective state and refers to an inability to be still; a motor restlessness which may produce a shaking of the hands or arms or feet or an irresistable desire to keep walking or tapping the feet. Pepper Tr. VIII, 22; Zander, supra; Winick, supra; Bugaosn, Tr. IV, 36. Both of these side effects are temporary and terminate either during or after the drug regime; the effects can also be treated with anticholinergic or antiparkinsonian drugs such as cogentin. Stinnett, Tr. XI, 95; DuBose, supra at 1203. However cogentin has side effects of its own, including blurred vision and salivation. Pepper, VIII, 28.

A potential permanent side effect of prolixin and other antipsychotic medication is tardive dyskinesia. Tardive dyskinesia is characterized by rhythmical, repetitive, involuntary movements of the tongue, face, mouth, or jaw, sometimes accompanied by other bizarre muscular activity. Winick, supra; Zander, supra; DuBose, supra; Greenberg, Tr. I, 28. The risk of this disorder is greatest in elderly patients, especially women, and is associated with prolonged use. Zander, supra at 40.

Finally, it should be mentioned that British researchers have suggested a link between prolixin and suicidal depression. Zander, supra. It is too early for scientists, much less this court, to draw any firm conclusions from this research. Stinnett, Tr. XI 37.

C. Lithium Carbonate

As lithium is another drug previously used and presently recommended by some doctors in Mr. Rennie's case, a short discussion is appropriate. Lithium carbonate is now established as the most effective treatment available for mania, an affective disorder marked by extreme elation, hyperactivity, grandiosity, and accelerated thinking and speaking. It also prevents the recurrence of both the manic and depressive episodes which alternately afflict patients with bipolar manic-depression. Winick, supra at 787; Pepper, Tr. VIII, 40; Testimony of Dr. Richard F. Limoges, Tr. XII, 27-29, 4/20/78. However, in a bipolar case, an antidepressant such as tofranil, amitripyene or imipramine must be added to prevent depression. Tr. VIII, 40; Tr. XII 29.

V. The Appropriate Treatment for Mr. Rennie

A. Plaintiff's Condition as of December 1977

It is at this juncture appropriate to resume the history of Mr. Rennie and the events which raised the forced medication issue. In early December 1977, the staff of Ancora felt that plaintiff was highly homicidal, and that his general condition was deteriorating. Bugaoan, Tr. III, 137-39. On December 5, a meeting was convened attended by Dr. Bugaoan, Dr. Pepernik, Dr. Ortanez, and the members of plaintiff's treatment team to discuss the situation. Ex. D-2; Bugaoan, Tr. IV, 94. The next day, Dr. Pepernik sought and received permission from the Attorney General's office to administer medication without consent. At a hospital treatment team meeting on December 7, a multi-modal treatment plan for plaintiff was formulated, including the administration of prolixin hydrochloride. The decision to compel medication was made to prevent plaintiff from harming other patients, staff, and himself and to ameliorate his

delusional thinking pattern. Prolixin was chosen because, in the decanoate form, it is the only injectable long-acting drug. Tr. IV, 121. It was thought that in the post-hospitalization period, it would be easiest to maintain Mr. Rennie on prolixin decanoate, with an injection every two weeks, since he had a history of failing to continue his medication once released. In the month following the initiation of the prolixin regime, Mr. Rennie's condition improved markedly. Ex. D-2; Tr. II, 129-30. After his dosage was lowered to 15 mg/day by the court order of December 30, it was reported that his behavior was controllable. However the staff psychiatrists felt the dosage to be insufficient to treat his thought disorder. Tr. III, 86.

B. Plaintiff's Diagnosis

Obviously, before drugs can be prescribed, plaintiff's condition must be known. Perhaps the question most contested during the hearings was plaintiff's proper diagnosis. While psychotropic drugs are generally regarded as the treatment of choice for schizophrenia, lithium, with an antidepressant, is the treatment of choice for manic depression. As plaintiff is presently willing to take lithium,[4] this case would be moot if manic depression were the consensus diagnosis.

As noted earlier, at various times during plaintiff's prior hospitalizations, diagnoses of both schizophrenia and manic depression were offered. There is a thin line between these two illnesses. Pepper, Tr. XIV, 78, 4/28/78. No expert indicated any medical agreement as to whether the two disorders arise from different environmental causes, or represent different physiological states within the brain. Instead, the testimony concentrated on

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4. In the past, Mr. Rennie has refused lithium, stating it made him too depressed. Greenberg, Tr. I, 35. His assessment of the drug was correct. At the time, the hospital apparently would not give him an antidepressant in addition to the lithium. Perhaps as a result of these hearings, all now agree that lithium is best at curbing the manic side of manic depression, and that in a bipolar case such as plaintiff's, an antidepressant such as tofrinil is also necessary. See Order Dissolving Temporary Restraining Order 4/18/78; Tr. XI, 139; Pepper, VIII, 40; Heller, XIII, 41, 4/25/78; Lineges, XII, 29.

symptomatology. Furthermore, there was little testimony on how the psychopharmacological substances work in the brain. This emphasis on symptoms and lack of certainty about causation and physiopathology demonstrates the tentativeness of much psychiatric diagnosis as compared to the usual physical diagnosis. The experts who testified concerning Mr. Rennie's disorder are in great disagreement. Drs. Heller and Bugaoan believe plaintiff is schizophrenic. Tr. XII, 40. Drs. Ortanez and Pepernik give a diagnosis of schizophrenia, affective type. Tr. III, 71, Tr. X, 109, but Ortanez agrees that plaintiff has also shown a manic depression symptoms at times. Tr. III, 75. Dr. Stinnett diagnoses plaintiff as manic depressive, but offers schizo-affective disorder as a possible alternative diagnosis. Tr. XI, 15. Finally, Drs. Limoges and Pepper feel that plaintiff suffers only from manic depression. Tr. XII, 32; VIII, 31.

There is much overlap between the two diagnoses and disagreement among experts. Manic depression is basically a mood disorder, while schizophrenia is primarily a thought disorder, characterized by delusions, hallucinations, and faulty logic. However, manic depressives can also show thought disorders at the manic end of the mood swing. But, true schizophrenia is characterized by sustained rather than episodic periods of thought disorder. Further, a manic depressive's periods of thought disorder will be tied to his mood swings, unlike a schizophrenic's cognitive dysfunctions. In addition, schizophrenics can show mood disorder as a secondary symptom. This is called schizophrenia, affective type, or schizo-affective disorder. Stinnett, Tr. XI, 20; Ortanez, Tr. III, 71.

The problem facing the doctors diagnosing Mr. Rennie is obviously complex. Simplified for the lawyer's mind, one of the key inquiries is whether Rennie's assertions that he is the "alpha omega," Tr. VII, 25, or Christ, are firm and fixed schizophrenic delusions or mere grandiosity characteristic of

his manic euphoria. Dr. Limoges believes the latter and thus would only prescribe lithium and an antidepressant to combat plaintiff's manic depression. Tr. XII, 26, 118-19.

Dr. Stinnett however testified that while his diagnosis was manic depression, the distinction is largely academic. He found the symptoms to warrant both antipsychotic medication and lithium. An antipsychotic was deemed necessary both to curb the patient's perceived delusions and to control the destructive aspects of his behavior. Tr. XI, 22-23. While Dr. Ortanez lacks Dr. Stinnett's experience and expertise,[5] as the treating physician Dr. Ortanez also believed that both antipsychotics and lithium would be appropriate based on his perception of combined symptoms.

A little knowledge can be dangerous, and this court is hesitant to diagnose mental illness and prescribe medication. But it is possible to draw these conclusions. Plaintiff is acutely psychotic at times. Stinnett, Tr. XI, 135. Aside from his adverse reaction to psychotropics, the best course of treatment for Mr. Rennie would combine psychotropic medication with lithium and an antidepressant. However, the position that he no fixed delusions, thus making use of a psychotropic unnecessary, is, at the least, a reasonable proposition.

C. Use of Pharmaco-therapy as the Sole Therapy

Defendants have produced at least one study, May, supra, demonstrating that drugs alone are an effective means of curing schizophrenia. Testimony has also indicated that drugs must be used initially to bring Mr. Rennie into contact with reality before any other therapy may be usefully employed. Bagaoan, Tr. III, 143; Stinnett, Tr. XI, 16; Heller, Tr. XIII, 33.

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5. In this case, opportunity to observe Mr. Rennie's everchanging symptoms may be the best way to arrive at an appropriate diagnosis. None of the outside experts besides Dr. Greenberg had this luxury.

However, the court rejects any solution to the problem of this case which would allow Mr. Rennie to be treated with an antipsychotropic drug alone. Dr. Stinnett expressed in the strongest possible terms that both pharmacotherapy and psychotherapy would have to be used to improve Mr. Rennie's conditions and not one without the other. The court fully accepts Dr. Stinnett's recommendation. Dr. Popper concurred in stating that medicine cannot be successful outside of a good total treatment plan. Tr. VIII, 34. Only in the context of a trusting relationship achieved through psychotherapy can medicine be employed in a rational way. Tr. XI, 16.

D. Plaintiff's Reaction to Psychotropics

John Rennie suffers from many of the side effects described above. He experiences blurred vision and a dry mouth. Rennie, Tr XIV, 144, 4/28/78. On Thorazine, his blood pressure has dropped. Tr. I, 35. He also suffers from akathesia on prolixin, getting uncontrollable tremors. Tr. XIV, 144. This, and the fact that he feels his senses are dulled, are his two principal reasons for refusal of prolixin. Tr. I, 35. Despite the hospital's assertion that Mr. Rennie has faked akathesia, Bugaoan, Tr. IV, 125, this court is convinced that the akathesia is real and extremely unpleasant. Pepper, Tr. VIII, 22; Keller, Tr. XIII, 22. The hospital doctors are to be faulted for ignoring plaintiff's subjective reports of akathesia while on prolixin. Stinnett, Tr. XI, 55.

Mr. Rennie also has shown wormlike movements of the tongue. This is a preliminary symptom which is possibly indicative that tardive dyskenesia may develop if medication is continued. Pepper, Tr. XIV, 34. Thus, there is a risk of permanent damage from Psychotropic medication in Mr. Rennie's case, and Mr. Rennie requires extremely close monitoring if these drugs are to be continued.

E. The Efficacy of Forced Medication

As noted above, a trusting relationship or therapeutic alliance between psychiatrist and patient is essential for a drug regimen to succeed. Stinnett, Tr. XI, 16; Limoges, XII, 73.

efficacious in a hostile or negative environment. Stinnett, XI, 35, 108; Pepper, VIII, 57. As a corollary to this, even if the best drug is prescribed, if the patient is unwilling to accept it, the positive effects are greatly lessened, especially in terms of long range benefits. Pepper, Tr. VIII, 76; Limoges, Tr. 72; O'Connor v. Donaldson, 422 U.S. 563, 579 (1975)(Burger, C.J., concurring

F. Plaintiff's Competency to Make Medication Decisions

John Rennie's psychiatric problems are of a cyclical nature, so that on some days he is psychotic. Dr. Pepper testified that plaintiff's refusal of prolixin is not a product of his mental disorder. Tr. XIV, 123. However, Dr. Stinnett found that during his examination on February 25, 1978, Mr. Rennie was not capable of making a decision on treatment in his best interests. Tr. XI, 112. The court feels that Dr. Pepernik's assessment is most accurate, and that Mr. Rennie's wishes should be taken into account on any treatment decision. But the court finds that his capacity to participate in the refusal of medicine or the choice of medicine is somewhat limited, depending on the day. Tr. VII, 24; cf. Shwed, Protecting the Rights of the Mentally Ill, 64 A.B.A.J. 564, 566 (1978); Comment, Forced Drug Medication, supra at 113. The court does believe that Mr. Rennie's reports of his subjective reactions to particular drugs are generally accurate.

CONCLUSIONS OF LAW

I. Introduction - New Jersey Law

A New Jersey state court has recently been faced with a factual situation very similar to this case. In re Hospitalization of B., 156 N.J. Super. 231 (Law Div. 1977) involved an involuntarily committed patient who was refusing prolixin. B had not responded to all conventional therapies, and the treating physician sought the court's permission to administer a psychotropic drug. B had not been declared incompetent. N.J.Ct.R. 4:83.



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Looking to the New Jersey statutes, the court quoted N.J.S.A. 30:4-24.2(a)(1), which states that:

> No medication shall be administered unless at the written order of a physician. Notation of each patient's medication shall be kept in his treatment records. At least weekly, the attending physician shall review the drug regimen of each patient under his care. All physician's orders or prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program. Voluntarily committed patients shall have the right to refuse medication.

Based on this statute the court held that involuntarily committed patients do not have the right to refuse medication. Involuntary patients "are protected by nothing more than the court's review, the occasional consultation of an independent expert, and the promised administrative procedure." 156 N.J.Super. at 238. Thus, plaintiff is proceeding under § 1983 to determine if the state scheme is constitutionally defective.

New Jersey does recognize the emerging right to treatment of mental patients. N.J.S.A. 30:4-24.1; State v. Carter, 64 N.J. 382, 393-04 (1974); see also Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

II. Standards on a Preliminary Injunction

Generally, four factors are to be considered on an applicati for a preliminary injunction: (1) whether the moving party has shown that it is likely to prevail on the merits, (2) whether the movant has demonstrated that he would be irreparably harmed if the preliminar injunction is denied, (3) whether the grant of the injunction would harm other interested parties to a greater extent than it would benefi movant, and (4) whether the public interest would be served. A. O. Smith Corp. v. F.T.C., 530 F.2d 515, 525 (3rd Cir. 1976). Defendants argue that there can be no showing of probability of success on the merits where novel legal issues are raised.

Certainly the issue of a federal right to refuse medication is novel and complex. However, the case has not followed the usual course of a preliminary injunction hearing. Hearings have been held on fourteen dates over a period of four months. The court has heard

testimony from nine psychiatrists. Counsel have aided the court with excellent briefs. Thus, while more information is always desirable, the court feels that it should not avoid a consideration of the merits in this instance merely because the issues are novel.

III. Abstention

Defendants argue that this court should abstain in this case so as to allow a state appellate court to consider the issue. Abstention is only appropriate in narrowly limited special circumstance Zwickler v. Koota, 389 U.S. 241, 248 (1967). It is proper when a federal constitutional claim is premised on an unsettled question of st law and where a state court decision on the state law issue might avoid the constitutional problem. Frederick L. v. Thomas, 557 F.2d 373, 381 (3rd Cir. 1977).

In this case, the state statute is clear. N.J.S.A. 30:4-24.2 (1) provides that voluntary patients may refuse medication, and thus by implication, involuntary patients may not. A recent state case, In re Hospitalization of B, supra, has settled the point. The fact that an appellate court has not decided the issue is not dispositive.

Furthermore, abstention is discretionary. Frederick L., supra at 382. It would be inequitable to send plaintiff back to state court at this stage of the proceedings. Therefore, the court will not abstain.

IV. The Federal Constitutional Issues

The plaintiff alleges numerous constitutional grounds in support of his position. These claims generally track the course charted in Scott v. Plante, 532 F.2d 939 (3rd Cir. 1976). See also Souder v. McGuire, 423 F. Supp. 830 (M.D. Pa. 1976). Scott, a patient of Trenton State Hospital, had five pro se complaints dismissed by the district court. One claim challenged the involuntary administration of medications, including thorazine, mellaril, and trilafon. The Third Circuit, in reversing the motion to dismiss, outlined in dictum how such a claim could establish a constitutional deprivation.

> ...[E]xisting case law points to at least three[9] conceivable deprivations that may accompany the involuntary administration of such substances by state officers acting under color of state law to inmates confined in a state institution. ...[T]he involuntary administration of drugs which affect mental processes...could amount, under an appropriate set of facts, to an interference with Scott's rights under the first amendment. See Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973); Kaimowitz v. Dep't of Mental Health, Civ. No. 73-19434-AW (Mich Cir. Ct., Wayne County, July 10, 1973). Moreover, on this record we must assume that Scott, though perhaps properly committable, has never been adjudicated an incompetent who is incapable of giving an informed consent to medical treatment. Under these circumstances due process would require, in the absence of an emergency, that some form of notice and opportunity to be heard be given to Scott or to someone standing in loco parentis to him before he could be subjected to such treatment. Finally, under certain conditions, Scott's claim may raise an eighth amendment issue respecting cruel and unusual punishment. See Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Mackey v. Procunier, supra at 878.

9. A possible fourth constitutional deprivation might include invasion of the inmate's right to bodily privacy...See, e.g., Roe v. Wade, 410 U.S.113...(1973). 432 F.2d at 946-47.

The court will consider each of these four claims in relation to the facts of this case.

A. Cruel and Unusual Punishment

As Dr. Rotov testified, Tr. VI, 141, 2/23/78, there is great potential for the abuse of psychotropic medication, and careful scrutiny is required when they are involuntarily administered. Comment, Advances in Mental Health: A Case for the Right to Refuse Treatment, 48 Temp. L.Q. - ', 364 (1975). The court will assume that the eighth amendment prohibition on cruel and unusual punishment does apply to protect persons confined in mental institutions. See Ingraham v. Wright, 430 U.S. 651, 669 n.37 (1977).

The question is whether use of antipsychotic drugs in plaintiff's case is justified as treatment or whether it can be classified as punishment by the court. Knecht v. Gillman, 488 F.2d 1136, 1138 (8th Cir. 1973). A number of cases have found eighth amendment violations despite claims of therapeutic value. Knecht, supra; Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973); Pena v.

New York State Division for Youth, 419 F. Supp. 203, 207 (S.D. N.Y. 1976); Nelson v. Heyne, 355 F. Supp. 451, 455 (N.D. Ill. 1972). However, each case is clearly distinguishable from the one at bar. In Knecht, the drug apomorphine was found to have no proven therapeutic value and its use was not recognized as acceptable medical practice. 488 F.2d at 1138, 1140; see Plotkin, supra at 494. Furthermore, while the behavior modification program was believed to have long-term benefits, the adverse effects seemed unnecessarily harsh. Comment The Right Against Treatment: Behavior Modification and the Involuntaril Committed, 23 Cath. U.L.Rev. 774, 782 (1974). In Nelson, Pena, and Mackey, the courts found that the drugs were used improperly and for punishment rather than as part of an on-going psychotherapeutic progra Cf. Welsh v. Likins, 373 F. Supp. 487, 503 (D. Minn. 1974).

In contrast, psychotropic drugs have been proven effective. Furthermore, the Ancora staff has established that they were trying to use prolixin as an integral component of an overall treatment program. While the side effects of prolixin are serious, they are not unnecessarily harsh in light of the potential benefits. According the court finds no eighth amendment violation. Prolixin was justifia administered as treatment, not punishment.

B. First Amendment

Another constitutional argument advanced in support of a right to refuse treatment is a first amendment right to freedom of expression, including both the right to communicate and the right to think. Plotkin, supra at 494. Plaintiff argues in this case that drugs may be used to punish or suppress truthful expression critical of the institution. Certainly plaintiff has a history of justifiably criticizing hospital procedure. However, there is no evidence that the hospital administered the medications in this case in an attempt to suppress those statements.

Plaintiff also argues that the use of drugs interferes with his mental processes and thus deprives him of his right to mentation. Kaimowitz v. Dept. of Mental Health, Civ. No. 73-19434 (Cir. Ct. Wayn County, Michigan July 10, 1973), reprinted in A. Brooks, Law, Psychiatry and the Mental Health System, supra at 902; Scott, supra

at 946; Comment, Advances in Mental Health, supra at 366.

In Kaimowitz, the court held that an adult may not give legally adequate consent to experimental psychosurgery, in part because of first amendment protection of the freedom to generate ideas. Any court must be deeply concerned with potential state control of individual thought and carefully scrutinize instances of forced psychiatric treatment.

In the case at bar, the court does not believe that first amendment analysis requires the use of drugs to be enjoined. First, Dr. Greenberg indicated that plaintiff's ability to perform on intelligence tests has not been impaired. Most importantly, plaintiff has indicated a desire to be cured of his mental illness. In this action, he is asserting a right to be treated, and has testified that he wants to be cured, not warehoused. Tr. XIV, 170. Thus, the hospital's efforts to alter his thinking disorder cannot be seen as a first amendment violation. The court need not reach the question of whether insane or disordered thought is within the scope of first amendment protection. Comment, Advances in Mental Health, supra at 366-67.

However, plaintiff also claims that a side effect of prolixin is that it dulls his senses and makes it difficult for him to speak. These side effects are temporary and expected to last only a few days or a couple of weeks, Pepernik, Tr. VII, 23, perhaps two months at the outside, Stinnett, Tr. XI, 132. This effect on mentation differs sharply from the problem faced in Kaimowitz. The patient in that case was to be subjected to experimental psychosurgery. The effects would be irreversible and unpredictable, the dangers to the patient substantial, and the benefits uncertain, with no scientifically established therapeutic effect. More specifically as to effects on the mental processes, psychosurgery flattens emotional responses and leads to lack of abstract reasoning ability, loss of capacity for new learning, and impairment of memory. Kaimowitz, supra at 909. In sum, if forced medication is otherwise proper, the temporary dulling of the senses accompanying it does not rise to the level of the first amendment violations found in Kaimowitz.

(1) Individual Interests

The court believes that any right to refuse medication in the absence of an emergency is best founded on the emerging right of privacy. The right of privacy is broad enough to include the right to protect one's mental processes from governmental interference. Kaimowitz, supra at 919; Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973); Stanley v. Georgia, 397 U.S. 557, 565 (1969); Comment, Advances in Mental Health, supra at 367; Comment, The Right Against Treatment, supra at 785. Additionally, privacy has been used to establish an individual's autonomy over his own body. Roe v. Wade, 410 U.S. 113 (1973); Runnels v. Rosendale, 499 F.2d 733, 735 (10th Cir. 1974); Comment, Forced Drug Medication, supra at 104. In other contexts, courts have established a constitutional right of privacy "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances." In re Quinlan, 70 N.J. 10, 40 (1976). This court holds that the right to refuse treatment extends to mental patients in non-emergent circumstances. Bell v. Wayne County General Hospital at Eloise, 384 F. Supp. 1085 1100 (E.D. Mich. 1974)(three-judge court); DuBose, supra at 1160; Zander, supra at 50. This accords with the usual common law rule against involuntary medical treatment. Winters v. Miller, 446 F.2d 65, 68 (2nd Cir. 1971); Scott v. Plante, supra. Only where the government shows some strong countervailing interest can the right to refuse be qualified. See 1 Report and Recommendation of the President's Commission on Mental Health 44 (1978); DuBose, supra; Szasz, Involuntary Psychiatry, 45 U. of Cin. L.Rev. 347, 356-57 (1976); Zander, supra.

The court feels that the recognition of a right to refuse treatment in a non-emergency situation is practical. The testimony has indicated that involuntary treatment is much less effective than the same treatment voluntarily received. The psychiatric experts state that it is more likely that a patient will consent to desirable treatment when consulted before action is taken, and when he feels

that he has some real control over his fate, than when he feels totally at the mercy of the hospital doctors.

Furthermore, only the patient can really know the discomfort associated with side effects of particular drugs. Again, the experts agree that they must rely on their patients for evidence of subjective feelings of pain associated with drug usage. Individual autonomy demands that the person subjected to the harsh side effects of psychotropic drugs have control over their administration.

It is also difficult for any person, even a doctor, to balance for another the possibility of a cure of his schizophrenia with the risks of permanent disability in the form of tardive dyskinesia. Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion.

Finally, the testimony in this case underscores the fact that psychiatric diagnosis and therapy is uncertain, with great divergence of opinion in any given case. O'Connor v. Donaldson, 422 U.S. 563, 579 (Burger, C.J., concurring). This also weighs toward leaving the final decision with the patient rather than deferring to doctors. Thus, the court concludes that it is appropriate to recognize a right to refuse treatment.

(2) State Interest

The constitutional right to refuse treatment cannot be absolute. Jacobson v. Massachusetts, 197 U.S. 11 (1905). The President's Commission charges all concerned with mental health laws to pay "careful attention to the circumstances and procedures under which the right may be qualified." Commission on Mental Health, supra at 44. Based on the evidence in this case, the court has identified three factors to be considered in overriding the patient's right to refuse.

First, the state's police power is often cited as one justification for the initial confinement of the mentally ill. The police power permits the state to confine a mentally ill person who

.presents a danger( ) himself or other membe( of society. O'Connor v. Donaldson, 422 U.S. 563, 575-77 (1975); Note, Wyatt v. Stickney-A Constitutional Right to Treatment for the Mentally Ill, 34 U.Pitt. L.Rev. 79, 82-83 (1972). The fact that the patient is dangerous in free society may give the state power to confine, but standing alone it does not give the power to treat involuntarily. Winters v. Miller, supra at 70. Once confined, the patient cannot hurt those outside.

However, the other patients in the hospital also have a constitutional right to protection from harm. Commission on Mental Health, supra at 44; Runnels v. Rosendale, supra at 735; Goodman v. Parwatikar, 570 F.2d 801, 804 (8th Cir. 1978); Welsch v. Likins, 373 F. Supp. 487, 503 (D. Minn. 1974). If a patient cannot be confine without endangering other patients and staff, and yet he refuses medication that would curb his dangerous tendencies, this would be one factor to weigh in overriding his decision to refuse. Comment, Forced Drug Medication, supra at 107.

The court found in this case that Mr. Rennie had shown frequ assaultive behavior while at Ancora. At times, this behavior led the Ancora staff to put him in restraints. Mr. Rennie has also complained bitterly about the use of restraints. However, in light of the hospital's duty to safeguard other patients and staff, plaintiff cannot both refuse his medication and be left free to inflict harm on others.

A second justification for involuntary confinement and treatment is the doctrine of parens patriae, under which the state cares for those unable to care for themselves. Note, Wyatt v. Stickney Constitutional Right to Treatment, supra at 82-83. It is clear that mental illness is not the equivalent of incompetency, which renders one incapable of giving informed consent to medical treatment. Scott v. Plante, supra; Plotkin, supra at 490, 496; Comment Advances in Mental Health, supra at 371; N.J.S.A. 30:4-24.2(c). Therefore, before the state can use parens patriae as a basis for medication, some hearing on the issue of competency must be held. Scott v. Plante, supra.

The factfinder of such a hearing must determine the extent to which the refusal of treatment is based on the underlying mental illnesses. Often, a characteristic of the illness is the inability to recognize and understand the severity of the problem. The greater the lack of insight, the stronger the impetus to override the right to individual autonomy. As stated by Judge Bazelon, "how real is the promise of individual autonomy for a confused person set adrift in a hostile world?" Bazelon, Institutionalization, Deinstitutionalization and the Adversary Process, 75 Colum. L.Rev. 897, 907 (1975).

If a factfinder is swayed to allow involuntary medication in part because of the patient's diminished capacity to care for himself, he should also consider the ability of the hospital to provide a reasonable full treatment plan. Since Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), courts have increasingly been recognizi a right to treatment. If a hospital cannot provide reasonable treatme services beyond the forcing of medication, one would doubt the appro-priateness of allowing that institution to act in parens patriae. Cf. Naughton v. Bevilacqua, 47 U.S.L.W. 2204 (D. R.I. October 3, 1978), which held that prolixin could not be used solely to control a patient behavior, without a habilitative purpose.

In the instant case, the court has found Mr. Rennie's decision-making powers to be somewhat impaired. However, the prior refusal of lithium without an antidepressant was well-founded, and the refusal of prolixin also had a rational basis. As previously noted, prolixin has been discontinued. If the state again seeks to medicate Mr. Rennie without his consent, the court will have to evaluate the basis for using that particular drug when the occasion arises. As part of that inquiry, it will be relevant to determine if Mr. Rennie understands that the alternative to accepting treatment may be permanent custody at Ancora.

As a final consideration, many courts and commentators have employed the concept of least restrictive alternatives in regard to the choice of a custodial setting. Welsch v. Likins, supra at 501; Gary W. v. State of La., 437 F. Supp. 1209, 1217 (E.D. La. 1976); Eubanks v. Clarke, 434 F. Supp. 1022, 1025 (E.D. Pa. 1977); Bazelon, supra at 901; Barnett, Treatment Rights of Mentally Ill Nursing Home

Residents, 120 U. Pa. L. Rev. 378, 390 (1971); Friedman, Legal Rights of the Mentally Handicapped: A Judge's Viewpoint, 60 A.B.A.J. 1371 (1974). The court feels that this concept should be extended to the choice of medications. Comment, Advances in Mental Health, supra at 376; Winick, supra at 813; Commission on Mental Health, supra at 44. Under this theory, a patient "may challenge the forced administration of drugs on the basis that alternative treatment methods should be tried before a more intrusive technique like psychotropic medication is used." Winick, supra.

In Mr. Rennie's case, psychotherapy had not proved effective. However, plaintiff's experts stated that lithium plus an antidepressant would be a reasonable therapy to which plaintiff would consent. Dr. Heller agreed that lithium and tofrinil was worth a trial. Tr. XIII, 41. Under these circumstances, the hospital is required to give Mr. Rennie a fair trial on the agreed upon lithium and tofrinil regime before seeking to medicate involuntarily the plaintiff. The notion of least restrictive alternatives can also be applied to the threat of tardive dyskinesia. If plaintiff is likely to contract tardive dyskinesia through renewed administration of psychotropic drugs, the cure would be worse than the illness, and involuntary medication would not be permitted.

Although another hearing may be required, the court does not intend to necessitate multiple hearings. The court wishes to avoid a cyclical situation where prohibition of treatment causes a patient's incompetency, upon which his doctors can then overturn his refusal and treat him with drugs, which then help him to regain competency and his refusal right. Instead, the court will, as much as possible, look to the proper treatment over the long term. Consideration of the least restrictive alternative is part of this long-term analysis.

To summarize, if the trial of lithium and tofrinil has failed and the state seeks to administer another drug which is refused by the plaintiff, the drug can only be administered in an emergency. For a long range program, the state must come back to court for further hearings. On the evidence to date, the court does not believe

that tardive dyskinesia is likely at this time; only a preliminary symptom possibly indicative of the disease has been shown. The court would find that all less restrictive alternatives have been exhausted if the lithium and tofrinil regime was given a fair trial. The court does find Mr. Rennie dangerous to others on the ward at times. Both his dangerousness and the rationality behind any new refusal would have to be evaluated at a new hearing. Furthermore, perhaps because he is a litigant, Mr. Rennie seems to be receiving an adequate treatment regime.

D. Due Process

In light of the extended nature of these hearings, Mr. Rennie certainly has received all the process to which he is due. However, in view of this court's practical experiences during this hearing, it is perhaps appropriate to comment on what the court feels are the shortcomings of the state's new Bulletin 78-3 regarding psychotropic medication, which appears as an appendix to this opinion.

First, the court finds that there is a sufficient liberty interest so that due process attaches. To go from a state of confinement to confinement plus forced medication involves a major change in the conditions of confinement, so that Meachum v. Fano, 427 U.S. 215 (1975) is inapposite. A drug regimen subjects a pacient to harsh side effects and possible permanent disability, effects different in kind than the differences between places of confinement. Furthermore, a hearing is required to insure that the use of drugs in a particular case does not violate the first or eighth amendments or the right of privacy. Thus, in the absence of emergency, some due process hearing is required prior to the forced administration of drugs. Scott v. Plante, supra. See also Clonce v. Richardson, 379 F. Supp. 338, 349 (W.D. Mo. 1974); Plotkin, supra at 491; Winick, supra at 816; Winters v. Miller, supra at 71. Cf. Bazelon, supra at 909.

A due process hearing is also required because there is great risk of hospital error. As we have seen, hospital records are difficult even for the staff to use. Entries are sometimes missed, and the complete drug history is not always clear. This underscores the need for systematic review of the decision to medicate involuntari

Initially, patients must be informed of and participate in the decision-making aspects of their treatment. In re W. S., Jr., 100 N.J.L.J. 1067 (Juv. and Dom. Rel. Ct., November 17, 1977).

Patients are entitled to a lawyer to assist them. Counsel is necessary to cope with the problems of law, to make skilled inquiry into the facts, and to insure proper procedures. Bell, supra at 1092 (quoting In re Gault, 387 U.S. 1, 36 (1967)); cf. Bazelon, supra at 910. It is clear in this case that without the tireless efforts of Mr. Gelman and his staff at the Public Advocates office, Mr. Rennie could not effectively have made an argument before a factfinder and brought his case before this court. See, Scott, supra at 950.

Independent psychiatrists are also essential to a fair hearing. Unless the state elects to set up some form of independent administrative board to review treatment decisions, the patient is entitled to an outside psychiatrist of his choice to evaluate the need for medication. See Senator Menza's Bill, Senate No. 1032 (October 23, 1975), vetoed March 4, 1976.

A hospital-retained psychiatrist is not sufficient. As Dr. Pepper testified, psychiatrists are as objective as lawyers when representing a client. When Dr. Pepernik and Dr. Stinnett reviewed plaintiff's files, they began with the assumption that the choice of prolixin was correct. Dr. Heller was also influenced by having the hospital doctors refer him to specific sections of the charts. Patients refusing treatment must be entitled to an outside consultant of their choice so that all of the facts can be aired.

The court also notes that once the outside consultants and hospital psychiatrists began talking, it was possible to reach areas of agreement and a fuller understanding of Mr. Rennie's problem. Thus, it believes that the presence of independent doctors will aid rather than inhibit treatment.

Finally, the patient's lawyer and psychiatrist must have access to hospital records to determine comprehensively the position of their client. Where the patient cannot reasonably afford an attorney or a psychiatrist, the state must supply them.

V. Conclusion

As the involuntary medication of prolixin was terminated, no injunction need issue on that point. Due to the time required for briefing and preparation of this opinion, over four months have passed since the parties were last in court. Accordingly, the court is not fully aware of the present status of Mr. Rennie and what effect an injunction would have.[6] Therefore, no injunction will issue at the moment. If Mr. Rennie now refuses any drug which the Ancora doctors seek to administer in a non-emergency situation, the court will upon notice restrain the administration of the drug and immediately schedule hearings to examine (1) plaintiff's physical threat to patients and staff at the institution, (2) plaintiff's capacity to decide on his particular treatment, (3) whether any less restrictive treatments exist, and (4) the risk of permanent side effects from the proposed treatment.

Stanley S. Brotman

STANLEY S. BROTMAN
United States District Judge

Dated: November 9, 1978

6. It is the court's understanding that as of the date of this opinion Mr. Rennie is not receiving psychotropic drugs, and may soon be released from Ancora.

APPENDIX

DIVISION OF MENTAL HEALTH AND HOSPITALS

ADMINISTRATIVE BULLETIN 78-3

March 1, 1978

SUBJECT: The Administration of Psychotropic Medication to Voluntary and Involuntary Patients

I. Introduction

A. Issue

Division guidelines governing the administration of psychotropic medication to voluntary and involuntary psychiatric hospital patients.

B. Objectives

1. To fulfill our ethical, professional and statutory responsibilities in improving the condition of psychiatric hospital patients;

2. To provide patients with the opportunity to participate in the development of their own individual treatment plans;

3. To provide for medical review of the treating physician's medication determination;

4. To utilize the patient's treatment team in formulating clinical care.

C. Legislative Parameters

1. Every individual who is mentally ill is entitled to medical care and other professional services in accordance with accepted standards. N.J.S.A. 30:4-24.1. New Jersey courts have also recognized that a psychiatric hospital patient has an affirmative right to receive treatment and that a hospital has a correlative responsibility to attempt to improve the condition of its patients.

2. Each patient has the right to participate in planning for his own treatment to the extent that his condition permits. N.J.S.A. 30:4-24.1.

3. (a) Voluntary patients have the right to refuse medication. N.J.S.A. 30:4-24.2. d (1).

(b) The chief executive officer of a state or county psychiatric hospital is authorized to give consent for psychiatric treatment to patients declared legally incompetent by a court or patients under the age of 21 under certain conditions. See N.J.S.A. 30:4-7.1 - 7.6.

(c) Patients have the right to be free from unnecessary or excessive medication. N.J.S.A. 30:4-24.1 d (1).

(d) Medication may not be used as punishment, for the convenience of staff, or as a substitute for a treatment program. N.J.S.A. 30:4-24.1 d (1).

(e) Notation of each patient's medication shall be kept in his treatment records. At least weekly, the attending physician shall review the drug regimen of each patient under his care. All physicians' prescriptions shall be written with a termination date, which shall not exceed 30 days. N.J.S.A. 30:24.2 d (1).

D. Judicial Parameters

Although existing case law is not clear with respect to the administration of medication to involuntary patients, in December 1977 a New Jersey County District Court Judge held, in the case of, *In Re Mark B.*, that under certain conditions, "Involuntarily committed patients do not have the right to refuse medication."

II. The Involuntary Administration of Medication

Definitions

1. A patient is considered incompetent only if he has been adjudicated incompetent by a court.

2. Medication is considered a necessary part of a patient's treatment plan when either:

(a) The patient is incapable, without medication, of participating in any treatment plan available at the hospital that will give him a realistic opportunity of improving his condition; or

(b) Although it is possible to devise a treatment plan that is available at the hospital and will give the patient a realistic opportunity of improving his condition; either:

(1) a treatment plan which includes medication would probably improve the patient's condition within a significantly shorter time period; or

(2) there is a significant possibility that the patient will harm himself or others before improvement of his condition is realized, if medication is not administered.

A. Emergency Administration of Medication

The procedures described in this Bulletin are not intended to preclude the administration of psychotropic medication to a patient in an emergency.

Therefore, if a physician certifies that it is essential to administer psychotropic medication in order to prevent the death of or serious consequences to a patient, the Chief Executive Officer is authorized to consent to the administration of the medication recommended by the physician's certification. If it is impossible to comply with this procedure without jeopardizing the life of the patient, the medication may be administered on a physician's order.

B. If a patient refuses to take the psychotropic medication that has been prescribed for him, the attending physician shall speak to the patient and attempt to explain: his assessment of the patient's condition; his reasons for prescribing the medication; the benefits and risks of taking the medication; and the advantages and disadvantages of alternative courses of action.

If the patient still refuses to take the medication and the physician still believes that medication is a necessary part of the patient's treatment plan:

(a) The physician should tell the patient that the matter will be discussed at a meeting of the patient's treatment team;

(b) If the patient's clinical condition permits, the physician should invite the patient, to attend the meeting of the treatment team.

(c) The physician should suggest that the patient discuss the matter with a person of his own choosing, such as a relative or friend.

C. The treatment team shall meet to discuss the physician's recommendation and the patient's response.

(1) If the patient is present, the team shall attempt to formulate a treatment plan that is acceptable to the patient and the team. The patient may agree to take medication unconditionally or under certain conditions that are acceptable to the physician.

(2) If the patient is not present, the team and the physician shall discuss the physician's recommendation and the patient's response, and shall document their respective conclusions.

D. If, after the team meeting, the physician still believes that medication is a necessary part of the patient's treatment plan and the patient still refuses to take the prescribed medication,

Then:

Case 1: Patients Adjudicated Incompetent by a Court

(1) If there is a consensus in regard to the necessity of the medication, the physician shall attempt to secure the consent of the patient's guardian.

If the patient's guardian, after reasonable notice of the proposed action and a request for consent, refuses or neglects to execute and submit a writing expressing either the grant or denial of consent,

Then, The Chief Executive Officer may consent to the administration of medication.

(2) If there is disagreement between the team and the physician in regard to medication, then the medical director (or his designee) shall conduct a personal examination of the patient and a review of the record. If the medical director (or his designee) agrees with the physician, the physician shall attempt to secure the consent of the guardian.

If the patient's guardian, after reasonable notice of the proposed action and a request for consent, refuses or neglects to execute and submit a writing expressing either the grant or denial of consent,

Then, The Chief Executive Officer may consent to the administration of the medication.

Case 2: Patients Who Have Not Been Adjudicated Incompetent by a Court

Part I - Voluntary Patients

Medication may not be administered to a voluntary patient who refuses to accept it.

Part II - Involuntary Patients

The medical director (or his designee) must conduct a personal examination of the patient and a review of the record. If the medical director (or his designee) agrees with the necessity for medication, the medication may be administered as a part of the patient's documented individualized treatment plan.

E. Miscellaneous

1. Independent Evaluations

Whenever the medical director (or his designee) is asked to review a medication decision, the medical director shall be authorized to retain an independent psychiatric consultant to evaluate the patient's need for medication. This would be indicated particularly in cases where there is disagreement between the treating physician and the team.

If the patient is evaluated by an independent psychiatric consultant invited by the hospital and the consultant recommends a treatment plan that does not include the administration of medication, then the medical director in the report filed in the treatment record, shall address the conclusions and recommendations of the consultant.

2. Review

In addition to the reviews mandated by N.J.S.A. 30:2[illegible].2 d (1), the medical director (or his designee) shall review each week the treatment program of each involuntary patient, who is refusing to accept medication voluntarily, to determine:

(a) Whether the patient is still refusing his prescribed medication;

(b) Whether medication is still a necessary part of the patient's treatment plan; and

(c) Whether the other components of the patient's treatment plan are being implemented.

3. Documentation

Each step of the procedures outlined above shall be documented in the patient's chart.

Michail Rotov, M.D., Director
Division of Mental Health and Hospitals

MR:jc

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

| | | |
|---|---|---|
| JOHN E. KENNIE, | : | Civil Action No. 77-2624 |
| Plaintiff, | : | |
| v. | : | |
| ANN KLEIN, etc., et al., | : | |
| Defendants. | : | S U P P L E M E N T A L<br>O P I N I O N |

APPEARANCES:

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ORIGINAL FILED
DEC 12 1979
ANGELO W. LOCASCIO, CLERK

BROTMAN, District Judge

This is a renewed motion for a preliminary injunction pursuant to Fed. R. Civ. P. 65 by plaintiff John E. Rennie, an involuntary patient of Ancora Psychiatric Hospital. He seeks to enjoin the defendant psychiatrists and officials at Ancora from forcibly administering drugs to him in the absence of an emergency situation. The complaint is grounded on 42 U.S.C. § 1983, with jurisdiction pursuant to 28 U.S.C. § 1343.

This court held fourteen days of hearings on the original motion between January 13 and April 28, 1978, and issued its opinion November 9, 1978. 47 U.S.L.W. 2353. Although the opinion discussed the facts of the case and legal issues at length, the court did not issue an injunction since the record did not reflect the plaintiff's then current status. Furthermore, the court had been informally advised by counsel that plaintiff's condition had improved substantially and release from the hospital was contemplated. The opinion left the courthouse door open for plaintiff to reapply for immediate injunctive relief if his condition worsened and the hospital again attempted to medicate plaintiff against his will in a non-emergent situation.

Unfortunately, the plaintiff's condition has greatly deteriorated in recent weeks, and as a result the hospital on December 2, 1978 began to administer the antipsychotic drug thorazine without plaintiff's consent. Plaintiff renewed his motion for an injunction on December 6, and a hearing was held the following day. After hearing the testimony of plaintiff's witnesses and the arguments of counsel, the court denied the motion. The following are the court's findings of fact and conclusions of law, Fed. R. Civ. P. 52, which supplement the findings and conclusions set forth in the November 9 opinion.

## FINDINGS OF FACT

### I. Plaintiff's Condition

Mr. Rennie's mental health began to deteriorate within a few days after the November 9 issuance of the earlier opinion. He became increasingly manic, exhibiting grandiose behaviors. Transcript

of December 7 hearing, pages 43-60, hereinafter cited as Tr. 43-60. By November 14, he was transferred to a closed ward and placed on homicidal precautions. His behavior has become increasingly abusive and assaultive, and he has suffered from inability to sleep and hallucinations. Tr. 31-37. He has been in restraints much of the time since November 14, and is currently in a state described by his treating psychiatrist, Dr. Engrazio Balita, as floridly psychotic. Tr. 28. His physical condition has also deteriorated, and he has suffered dehyration, abnormal fluctuations in temperature, and probable infection. Tr. 28-31. Dr. Balita testified that these complications have imperilled his life. Tr. 28.

Mr. Rennie has been on a maintenance dosage of lithium carbonate. However, while on a furlough from Ancora the first week of November, he stopped taking this medication, Tr. 45, and refused it upon returning to the hospital.[1] Tr. 48. However, after appeals from his counsel, Mr. Gelman, he began taking lithium November 14 and attained a maintenance level of the drug in his blood on November 24. Tr. 50-58.

As the lithium failed to stabilize plaintiff's condition, Dr. Balita began emergency injections of thorazine on December 2, and at a treatment team meeting December 5 recommended that thorazine be forcefully administered in accordance with Administrative Bulletin 78-3. This recommendation was approved at the meeting, and reviewed and approved the following day by Dr. Max Pepernik, the Ancora Medical Director. Tr. 9, 27.

## II. The Four Factors

In the November 9 opinion, the court stated four factors which must be considered in determining if an injunction should issue. These are (1) plaintiff's physical threat to patients and staff at the institution, (2) plaintiff's capacity to decide on his particular treatment, (3) whether any less restrictive treatments exist, and (4)

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1. Dr. Balita testified that plaintiff's persistence in refusing lithium was buoyed by the court's November 9 opinion (though that opinion approved use of that drug). Tr. 30. The doctor also stated that Mr. Rennie's discussion of the opinion in a hospital ward for the criminally insane encouraged other patients in that ward to refuse medication. Tr.49

the risk of permanent side effects from the proposed treatment. These factors will now be applied to the current situation.

Plaintiff has repeatedly threatened patients and staff during the past few weeks, and has been put on homicidal precautions by the hospital. Tr. 49, 53. It has often been necessary to place him in restraints to protect the plaintiff himself as well as others in the institution. Tr. 68.

The court accepts Mr. Gelman's representation that in his current psychotic thrall Mr. Rennie has still knowingly refused to consent to injection of thorazine. Tr. 4. But as the court indicated in its November 9 opinion, his capacity to participate in the choice of medication is limited. Plaintiff's failure to take lithium the last several weeks is additional evidence of his limited capacity to make treatment decisions, as the expert testimony is almost unanimous that lithium is a helpful drug with only minor side effects to Mr. Rennie. It should be noted that he has not only refused lithium while in his current manic state, but also early in November when his condition had markedly improved.

Analyzing plaintiff's behavior, the court concludes that while his refusal of thorazine is partly motivated by a rational desire to avoid harmful and unpleasant side effects, it is also prompted by an irrational desire to rebel against the hospital and its doctors. Therefore the court finds that plaintiff's capacity is severely limited, particularly at the present time, but also over the course of his illness. However, if plaintiff continues his present cooperation with the doctors in taking lithium for a few months, the court might reconsider this finding of lack of capacity. On the other hand, Mr. Rennie need not consent to psychotropic medication to demonstrate capacity, as his refusal of these drugs at this time has, at the least, a rational basis. The court may reconsider this finding at a later time, however.

As was stated in the court's earlier opinion, the lithium regime must be given a fair trial as a less restrictive treatment. Plaintiff's expert, Dr. William T. Carpenter, testified that lithium

has not yet had a complete chance, Tr. 211, but this is partly because plaintiff has failed to take the medication. Tr. 46.

Even plaintiff's expert indicated that a psychotropic was essential to stabilize Mr. Rennie. He recommended that thorazine be administered for at least one week or until Mr. Rennie's condition had stabilized to the point where he could be released from restraints and lithium and psychotherapy could be effectivaly employed. Tr. 114.

The court therefore finds there is currently no less restrictive alternative to thorazine, other than constant restraints, which will safeguard plaintiff and others in the hospital, and no alternative treatment which offers a reasonable chance of alleviating plaintiff's current acute psychosis. The court further finds that this situation will continue until the plaintiff's condition has stabilized and improved, and until plaintiff demonstrates a convincing willingness to participate in a lithium and psychotherapy regime.

Finally, the court must consider the risk of permanent side effects. The court is concerned about tardive dyskinesia which, as stated in the earlier opinion, is a cure worse than the mental disorder itself. While Dr. Carpenter testified that he had observed mild abnormal movements of the jaw and extremities at an August 24 examination of Mr. Rennie, Tr. 91-92, plaintiff's counsel conceded that plaintiff has no symptomatic movements at this time. Tr. 79. Dr. Carpenter concluded that Mr. Rennie may have had a very mild, reversible case of tardive dyskinesia, and at least has a predisposition to the disease. Tr. 92-93. However, he also indicated that short-term use of thorazine does not pose a significant threat, though he cautioned against use of thorazine for more than four weeks, particularly if the drug does not greatly affect Mr. Rennie's psychosis. He also stated Mr. Rennie should be watched closely for manifestations of tardive dyskinesia symptoms. Tr. 115-25.

The court agrees that close scrutiny is vitally necessary, but does not believe that the threat of the disease is salient enough to preclude use of thorazine at this time.

CONCLUSIONS OF LAW

As plaintiff's capacity is severely limited, and as thorazine injections provide the least restrictive means to stabilize plaintiff's condition in order that lithium and psychotherapy may be used (with or without thorazine), and in order that the hospital may safely remove plaintiff from restraints, no injunction will be issued.[2]

The court has indicated its desire to avoid multiple hearings by examining the situation over the long term at this injunction hearing. However, the need to administer thorazine for a week or two became readily apparent, and the court did not require defendants to call their witnesses and provide their long-term treatment plan.[3] Neither did the treatment team evaluation of December 5 indicate how long thorazine will be used. Furthermore, as plaintiff's counsel, Mr. Gelman, conceded at the hearing, it was not the best time in plaintiff's view to decide his long-term care. Tr. 72.

But consistent use of lithium for several weeks is required to demonstrate plaintiff's renewed capacity to choose his treatment, as well as to enable the hospital and this court to confidently assume that lithium and psychotherapy alone may be given a realistic trial through proper use. Therefore, this decision should be conclusive for at least two months, barring any significant evidence of tardive dyskinesia or drastic change in any other relevant factor in the court's decision. The court is still very concerned about the

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2. The Attorney General has indicated that he may wish to appeal this decision despite the favorable outcome because of the court's statements on the law. The court will consider an application for certification to appeal under 28 U.S.C. § 1292(b) when such a petition is made. Subsection (b) certification may be used for the purpose of avoiding serious harm to a litigant pendente lite from an erroneous interlocutory order. Katz v. Carte Blanche Corp., 496 F.2d 747, 754 (3rd Cir.), cert. denied, 419 U.S. 885 (1974).

3. A plan will be required by the pre-trial order in this case, so that long-term use of psychotropics may be fully considered when the consent to treatment issue is tried.

possibility of tardive dyskinesia and urges the hospital to monitor Mr. Rennie closely for signs of this disease. Furthermore, the court stresses that the hospital should carefully consider the need for continued administration of thorazine in light of objective medical evidence and plaintiff's refusal of the drug. The court hopes that reasoned action by both parties will preclude the need for further applications for preliminary injunctive relief.

Both parties have also asked the court to clarify the procedures for seeking an injunction established in the November 9 opinion and the definition of the term emergency used in the opinion. These procedures will apply to any later appeal by plaintiff for injunctive relief on this issue. Emergency signifies a sudden, significant change in the plaintiff's condition which creates danger to the patient himself or to others in the hospital. While restraints can always eliminate this danger, Tr. 68, this is a realistic alternative only if a few hours' confinement are adequate to calm the plaintiff. Otherwise the hospital is not required to place the plaintiff in permanent restraints rather than forcefully medicate.

The emergency is deemed to last until the administrative procedures under Bulletin 78-3 may be followed, but no longer than 72 hours regardless. At that time, plaintiff may, if he wishes, seek a temporary restraining order by notifying the court and the state, and presenting evidence that psychotropics are being forcefully administered. Then the court will issue the restraining order and immediately schedule a preliminary injunction hearing, to be held within 72 hours if possible, to consider the right to refuse treatment under the four stated factors.

STANLEY S. BROTMAN
United States District Judge

Dated: December 12, 1978

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Nos. 79-2576/79-2577

JOHN E. RENNIE

vs.

ANN KLEIN, COMMISSIONER OF HUMAN SERVICES; MICHAIL ROTOV, DIRECTOR, DIVISION OF MENTAL HEALTH AND EXECUTIVE OFFICER OF ANCORA PSYCHIATRIC HOSPITAL; MAX PEPERNICK, ACTING MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL; EDWARD WALLACE, ASSISTANT ADMINISTRATOR OF ANCORA PSYCHIATRIC HOSPITAL; and JOSEFINA BUGAOAN, ASSISTANT MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL

John E. Rennie, plaintiff, on behalf of himself and all others similarly situated, and Caroline Mauger, Eugenio Burgeos, Leon Rossi, Hazel Moncrief, Ernie Welker, Mary Jane Weiss, Margaret Mary McGrath and Joseph Kamienski, Intervenors, on behalf of themselves and all other similarly situated,
Appellants in No. 79-2576

Ann Klein and Michail Rotov,
Appellants in No. 79-2577

(D. C. Civil No. 77-2624)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

Present: SEITZ, Chief Judge ALDISERT, ADAMS, GIBBONS, HUNTER, WEIS, GARTH, HIGGINBOTHAM and SLOVITER, Circuit Judges

JUDGMENT ON REHEARING

This cause came on to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel on April 22, 1980 and reargued before the Court in banc on May 12, 1981.

On consideration whereof, it is now here ordered and adjudged by this Court that the within cause be, and the same is hereby remanded for further proceedings consistent with the opinion of this Court. Each party shall bear its own costs.

ATTEST:

Sally Dworak

Clerk

July 9, 1981

Appendix G 18

# Appendix

# 2

NO. 81-5534

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

JOHN E. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MAY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

PETITIONERS,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

RESPONDENTS.

APPENDIX H, PART 1, TO PETITION
FOR WRIT OF CERTIORARI

Michael L. Perlin
Director
Department of the Public Advocate
Division of Mental Health
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STANLEY C. VAN NESS
PUBLIC ADVOCATE

Sheldon Gelman, Esq.
J. Benedict Centifanti, Law Clerk

On the Petition

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
CAMDEN, NEW JERSEY
CIVIL ACTION NO. 77-2624

JOHN E. RENNIE,

Plaintiff

vs.

ANN KLEIN, COMMISSION OF HUMAN SERVICES, MICHAIL ROTOV, DIRECTOR, DIVISION OF MENTAL HEALTH AND HOSPITALS, RICHARD WILSON, CHIEF EXECUTIVE OFFICER OF ANCORA PSYCHIATRIC HOSPITAL: MAX PEPERNIK, ACTING MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL: EDWARD WALLACE, ASSISTANT ADMINISTRATOR OF: ANCORA PSYCHIATRIC HOSPITAL: AND JOSEFINA BUGAOAN, ASSISTANT MEDICAL: DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL,

Defendants.

VOLUME XIV

TRANSCRIPT of the above captioned matter was taken before the Honorable Stanley S. Brotman, Judge, United States District Court, District of New Jersey, Camden, New Jersey, on Friday, April 28, 1978.

* * *

APPEARANCES:

STANLEY C. VAN NESS, Public Advocate
BY: SHELDON GELMAN, ESQUIRE
For the Plaintiff

WILLIAM P. HYLAND,
Attorney General of New Jersey
BY: STEVEN WALLACH, Deputy Attorney General
For the Defendant

Appendix H 1A

the stand, please.

JOHN E. RENNIE, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. GELMAN:

Q John, do you know the purpose that we are here for?

A Yes, I do.

Q What is it?

A To determine if prolixin should be administered to me.

Q Do you want to take the drug prolixin?

A No. I don't.

Q Why?

A Because it makes me feel very depressed and at times I get suicidal with it.

Q Have you told this to your doctors?

A Yes, I have.

Q What about the drug lithium?

A Well, lithium I have no side effects with that. I don't mind taking that.

Q Are you sure it does you any good?

A I am not sure.

Q Does it do you any harm?

A I am not sure the medication does me any good.

2k

Q Are you willing to take drugs that don't do any harm to you?

A Yes.

Q What do you think of Dr. Marvin Greenberg?

A He is a psychiatrist. He's easy to get along with. He's friendly. We have established a good meaningful relationship.

Q Do you think of him as someone who just comes to see you to have a good time?

A Well, I think he is sincere, interested in my welfare. I think he is interested in improving the system at Ancora.

Q Is he some kind of doctor?

A He is a medical doctor. He is a psychiatrist at the institute in Philadelphia.

Q Have you talked with Dr. Greenberg about going to the institute?

A Yes, I have.

Q What did he say?

A I have asked him if it were possible that I could sell my home and spend six or seven weeks at the institute.

Q How many weeks?

A Six or seven.

Q Why that number?

A Well, that is just an arbitrary figure that I came up with.

Q What drugs areyou taking now?

A Lithium.

Q Lithium?

A Yeah.

Q Anything else?

A Yes. I forget the name of it.

Q Do you know what the drug is supposed to do?

A Yes. It is an antidepressant.

Q Have youhad a pillow to sleep on at Ancora?

A Off and on. I have none now.

Q How did you get to know me?

A Well, I was having trouble with brutality. I was calling around to various prosecutors. One referred me to your office.

Q Did my office do anything for you?

A Yes, you did. Within two days you sent Laurie Roth and Judy Cracker to interview me about the violations of my patient's bill of rights.

Q What violations were we talking about?

A The twenty-four bill of rights and we had violations on twenty-four out of twenty-four rights.

Q Do you remember what some of them were, John?

A Excessive medication. I can't remember.

There is brutality, rights of humane treatment. I can't remember all of them.

Q What about Rose Sevilla? Do you know her?

A Yes, I do.

Q What does she do?

A She is a patient advocate at Ancora Hospital.

Q Have you dealt with her?

A Yes, I have.

Q What kind of things do you talk to her about?

A Patient rights and medication problems and then just generalities.

Q Do you trust Dr. Greenberg?

A Yes, I do.

Q Would you trust him to give you medication?

A Yes, I would.

Q Why?

A Because he don't want touse it as a sole means of treatment. He wants to use it just as an aid to treatment, not just the sole means. At Ancora you just take medication as a sole means of treatment.

5h

Q. Did the other patients at Ancora know about your case here?

A. A few of them do,yes, they do, very concerned about it.

Q. Why?

A. Because they feel their rights are being abused and very concerned about it.

Q. Were you showing some of these court papers to those patients?

A. Yes, I was.

Q. What happened?

A. The patients first seemed, didn't seem it was possible to enforce any of their rights. They thought that they're fighting a losing battle and they finally realized the advocate inTrenton was out to help them in improvement of hospital and the United States.

Q. Do other patients complain as much as you do about their rights?

A. Well, some of them are a little -- some are scared about talking about it than I am. I use to be more vocal than I am right now. I use to, you know, get on the phone all the time to complain about my rights.

Q. You don't do that any more?

A No.

Q Why?

A Well, for one, I have no phone service and then I have protection of the Federal Court right now and a lot of the use of restraints and forced medication and IM injections have been discontinued.

Q For you or for all the patients?

A Well, it's, it's slacked down for all the patients.

Q Do you remember anytimes when you were tied up or restrained?

A Yes, I do.

Q Would it bother you to tell us about some of them?

A Well, sometimes they tied a restraint so tight the blood circulation is cut off from your hand and your hands puff up and you need a drink and they won't give it to you and you start to complain and they ignore you and you try to struggle to get untied and they come in and keep tying more and more knots and tighter and tighter and next you know you're kicking the mattress underneath you, youare on the springs trying to get inside. It's very painful and frightening experience.

Q Are you afraid onyour ward?

Tk

A Yes, I am.

Q Why?

A Well, it seems the staff, because they have, they have limited numbers, forced by means of control and they threaten the patients and they actually have in one occasion, my case, they got in a fight with me and knocked my hearing out. I couldn't hear for about four months.

Q Do you remember complaining about sticks being on the ward?

A Yes, I do.

Q What happened?

A Well, I was tied down very tight one day and when they came into feed me supper, they made me, they take my food lying horizontally and I couldn't drink the fluids and then I got a patient, a patient felt sorry for me and I was hurting. My arm was, my hands were all puffed up. I couldn't stand it and when the patient untied me and then an attendant came in to tie me up and I started kicking at him. So he couldn't tie me up. So he went in and got sticks and came in and started hitting me with the sticks and it's not uncommon to use even the pipes to threaten patients. They threaten me with a pipe myself one time. I seen them use the pipes on patients who are

8h

bigger than they are.

Q Did the Public Advocate complain to the hospital, if you know about this?

A Yes, they did.

Q Did you see letters that we sent?

A Yes, I did.

Q Did anything happen?

A Well, they had the safety officer investigate and they found the sticks in the ward and pipes in the ward and the pipes were removed and the sticks then they haven't showed up.

Q Do other patients know about the sticks, John?

A Yes, they do.

Q Do you know why they didn't complain?

A They're fearful against them.

Q Have you, do you have a wardrobe?

A No, I don't.

Q What happened to it?

A I had -- when I got, when I came from one ward to another my wardrobe was removed from me. I don't have it. I don't have any place to put my clothes.

Q What about clothing, do you have all the clothes you had three months ago?

A. No, I don't. No place to store the clothes and all I had were taken away from me by other patients or I passed them out.

Q. Who is Joyce Weston?

A. She is a LPN that works on Holly C.

Q. Has Joyce tried to help you?

A. Yes, she has.

Q. Is Joyce still a nurse on your ward?

A. No. She's still Holly Hall C. I got transferred to Holly D.

Q. Who did youfeel most comfortable with at the hospital, just the people you feel most comfortable with?

A. Well, Rose Swelto, Fred Butcher, Joyce Weston.

Q. Who is Fred Butcher?

A. The chaplain. His secretary.

Q. Why do you feel comfortable with those people?

A. Because they're concerned about my well being.

Q. What is Reverand Butcher do for you?

A. Well, he tries to give me spiritual counseling and guidance and offers the substitute for medication by giving me psychotherapy on a schedule basis. Make an appointment to go see him and then right now he is handling my financial affairs while in the hospital.

10h

Q Why is he handling your financial affairs?
A Because we're friends.
Q Did you ask him to do it or does he claim the right to do it or what?
A Well, it was my mutual consent.
Q Do you own any clothing of your own now?
A No, I don't.
Q Do you have any income coming in?
A Social Security checks.
Q Do you get that?
A No, I don't.
Q What happens to it?
A It goes to the hospital.
Q Did you ask the Public Advocate to bring this lawsuit for you?
A Yes, I did.
Q Why?
A Because I was, I felt that the medication was being forced to me for punishment because one day I was using the telephone to call, I'm not sure who I was calling but, I was getting, I guess boisterous in the eyes of the attendant and he decided to restrain me and as the attendants were restraining me, I kicked one of them because they were choking me. Then when Dr. Bugenon found out that the attendant

I was hurt in the crash, and started to cry on IV injections of thorazine and she was on valium against my will.

Deb-D1

Q Were you ever on the drug thorazine?

A Yes, I was.

Q Did it do anything to you?

A Yes. It lowers my blood pressure. It gives me a sense of chills. Then when I go outside in the sun, I get sunburn from it. I can't stay out in the sun, but just for a very short period of time. In the summer I can't go out at all.

Q Do you get to go outside much?

A Very little.

Q Why?

A Because there is limited staff.

Q You can't go outside by yourself?

A No, I can't.

Q What about the food at Ancora?

A It's garbage.

Q Is it garbage everywhere in the hospital or in some places?

A Well, the transition unit they would buy food and cook their own food.

Q Do you have a treatment team?

A Well, they made one up for the court hearing and then it lasted about a week and stopped.

Q Who was on this team?

A Dr. Ortanez, the occupational therapist, the

13h

1 music therapist and psychologists and what have you.
2 Q What does Dr. Greenberg do when he sees you?
3 A Well, he brings in people who are friends
4 of mine. We just have a session among friends
5 discussing mutual problems.
6 Q Did Dr. Greenberg talk to you about prolixin?
7 A I don't recall him mentioning it.
8 He may have mentioned it.
9 Q Do you think of Dr. Greenberg as a psychiatrist?
10 A No, I dont. I think of Dr. Greenberg as
11 a friend. I call him Marvin.
12 Q Do you know how much he costs a week to
13 see?
14 A $200 a week.
15 Q Do you think he is worth it?
16 A I don't know.
17 Q That's a lot of money?
18 A It's a lot of money. If I were rich, I
19 would say it was worth it, but since I am on Social
20 Security, it's an awful lot of money.
21 Q Were you a pilot?
22 A Yes, I was.
23 Q What kind of work did you do as a pilot?
24 A Well, I flew executives around. I flew cargo.
25 I took flight instructions for private pilot,

commercial pilot, air transport flight industry pilot.

Q Did they have occupation therapy at Ancora?

A Yes, they do.

Q What is that like?

A It is an arts and crafts class. You work with wood and little lace. Items of that nature.

Around 10 o'clock we have a coffee break and we chit-chat for a little while.

Q Would you like a drink?

A Thank you.

Q Aside from depression, can you think of any other problems you have had on medication?

A Well, on prolixin I get the shakes. My body was shaking so bad I couldn't sit still. I would pace the floors a lot. I couldn't lay in bed. My mouth would get dry. I just -- my tongue would swell up. I feel like it wouldn't fit inside of my mouth. I get blurred vision. I get double vision.

Q What does it feel like when you have the jitters?

A It's scary because the doctor keeps saying that it is not the medication and you just can't stop it. They tell you to stand still for a second

15h

and for a moment you can stop it. But then in the long run you can't stop it. It shakes all the time. You shake day and night around the clock, week after week.

Q Is that why it is frightening because you can't control it?

A Can't control it; right.

Q Does it make you feel anything else?

A Well, it gets you -- it increases your depression. At times it makes you want to kill yourself.

Q You feel high sometimes?

A Yes, I do.

Q Low sometimes?

A Yes, I do.

Q How do you feel now?

A I feel low. Well -- I feel more comfortable now than when I was sitting down before.

Q Are you starting to get used to talking from the witness box?

A Yes.

Q Have you had hearings in state court?

A Yes, I have.

Q What are they like?

A Well, most times the hearings in state court I

16h

was so dazed from the medication I couldn't talk. Then when you go to the hearing you just have about 15 minutes with an attorney to tell your side of the story. When you go before the state judge you can't hardly say anything.

Q Do you prefer this kind of court case or the state court case?

A This case by far.

Q Why?

A Because the Judge is giving time for all the facts, both the good and the bad to come out, and give everybody a chance to get the full record.

Q What about haldol?

A Haldol gave me the shakes so bad that the nurse had to give me an injection to stop the medication reaction and took me off haldol.

Q Can you think of any other drugs that you were on?

A I have been on so many drugs I have lost confidence in drugs.

Q When were you first admitted into Ancora?

A In 1973.

17h

-2 Deb 1 Q you had been admitted and discharged a lot
2 since then?
3 A Yes.
4 Q What was the longest you stayed out of
5 Ancora?
6 A I believe I was out twice for a period of
7 about nine, ten months.
8 Q Were you taking medication?
9 A No, I wasn't. At times I was taking
10 medication with short periods of time, but back
11 in a week or two.
12 Q Are you able to go to church services when
13 you like?
14 A Since the play part I was involved in has
15 more access to the chapel, but not as much as I
16 would like.
17 Q What about letter writing materials?
18 A Almost non-existent. I haven't ever seen
19 it, I don't think.
20 Q How do you get in touch with your doctor
21 at Ancora?
22 A My doctor?
23 Q Well, most of the time you have to catch
24 them when they come on the ward because if you tell
25 the nurse sometimes and because the doctors aren't

18h

on the ward that much, it is kind of hard to get in contact with the doctor. You catch them in the hallways.

Q Do you remember being on prolixin in March?

A Yes, I do.

Q How were you feeling?

A Depressed.

Q Did you try and see a doctor?

A Yes, I did.

Q What did you do?

A Well, I asked the nurses, I said I was depressed and wanted some antidepressants. They had to get in contact with the doctor. Finally they contacted the doctor. She said yes, we should get him some antidepressants, but she never did anything about it, and nothing came of it.

Q Do you remember telephoning Judge Brotman?

A Yes, I did.

Q Why did you do that?

A Because I knew that the Judge wanted me to take the medication and I was complying with his order. I felt that if I exhaust all possibilities at Ancora for help, if I called the Judge's chambers and talked to the Judge, that possibly he could talk to the doctor about the medication.

19 h

Q John, what would you like to happen to you?
A To me?
Q Yes.
A Well, I would like to have more sayin regards to what medication they put in my body on the bad side effects that I would -- I should have some say over it. I am hopeful that the hospital can be improved where there is more staff, more facilities, and that there is more treatment in the community instead of in the hospital. You get treated in the community.
Q Do you remember a list of ideas for the hospital?
A Yes, I do.
Q Was that yours?
A Yes, it was.
Q Why did you write that up?
A I wrote it up because I felt that the hospital wasn't using any initiative to improve the hospital. They are just letting things go. I drew a list of what I thought were good ideas and sent them to the hospital staff.
Q Is there anything else that you would like to say now to the Court?
A I can't think of anything else that I

would like to say.

MR. GELMAN: I have no more questions.

THE COURT: Mr. Wallach, you may proceed, sir.

CROSS-EXAMINATION

BY MR. WALLACH:

Q Mr. Rennie, do you view Dr. Greenberg as a colleague of yours?

A Well, when he first came to the hospital, yes, I do view him as a colleague. He is a real friend to me right now.

Q Were you present in Court when Dr. Popernik testified that the hospital was not planning to use the drug prolixin with you any more?

A I don't recall that, sir.

Q You have stated that you do not want to take the drug prolixin?

A Right.

Q How do you feel about taking any other anti-psychotic drugs?

A Well, on most of these anti-psychotic drugs I get bad side effects. I don't feel that they help me out any. I take them for a prolonged period of time, you know it seems to be doing more

21-A

harm to me than good.

Q You have taken lithium in the past, haven't you?

A Yes, I have.

Q Did you ever stop taking the lithium?

A Yes, I did.

Q Why did you stop?

A Because I felt lithium, they weren't giving me enough medication of lithium. I felt I was immuned to it. So I stopped taking it.

Q Did you want them to give you more lithium?

A Yes, I did.

Q But they wouldn't give you more lithium?

A They wouldn't give me any more.

Q Did they give you any reason.

A Well, I believe that Dr. Ortanez told me the FDA said that is all we can give you, two capsules three times a day at maximum. That was taking the legal maximum as far as the number of pills were concerned.

Q Didyou ever feel any side effects when you were taking lithium?

A I don't recall any off hand, but all the pills I have been on, I have had the least side effects from the lithium. Onyonly bad thing about

lithium, the tablets they give you a very bitter taste in your mouth. When they give a lot of tablets, it makes your mouth taste pretty bad. When I was discharged two years ago and on the outside, I got lithium in capsules. I would usually take them in tablets. They don't have capsules in Ancora. I wanted to but capsules, but the pharmacy wouldn't go along with it.

Q Did you ever complain that the lithium made you depressed?

A I know I have been depressed on lithium. I'm not sure that's from the side effects of the drug or from my own, my illness. I'm not sure.

Q You testified before that you didn't have any of your clothes?

A No, I didn't.

Q Do you ever give your clothes away?

A At times I do, yes, I do.

Q Mr. Rennie, have you ever made any threats to President Carter?

A Well, yes, I have.

Q Could you tell us why, please?

A Well, I felt that I was wronged by the American System of Mental Health and I've gotten all kinds of people trying to change the system around, local, state and federal and even went to the White House. All I got was an interview with a secret service agent. Then I got very bitter at the American public. They wasn't concerned about mental health and then in desperation after being locked in a mental hospital so dogone long, I lashed out at anybody I could think of and I lashed out at the President because he was

24h

the symbol of the American democracy.

Q Have you done this several times or once?

A I have done it a lot of times. I haven't done it for quite a while now, though.

Q Have you done it in the last couple of months?

A No.

Q The various times you have been released from the hospital, how did you end up coming back?

A Well, I wanted to get some kind of vocational rehabilitation or my pilot's license back and so I tried to go to people to try to get some kind of training or get my pilot license back. Then they looked down on people who have been in mental hospitals and they start giving you the runaround and so if I, when I raised my voice up a little bit, they take and shoot me back to the hospital and don't give me a chance.

Q Can you think of any other reason why you've been sent back to the hospital?

A Not offhand, no.

Q You were at Fairmont Farms Hospital a few times, is that correct?

A Yes, I was there twice.

Q How are you feeling today?

A A lot better than it was. But, they give me electric shock therapy and that affects my memory. Until this very day my memory is very bleak. I can't use it at times.

Q Would you like to leave Delaware Hospital now?

A Yes, I would.

Q What would you do if you were released?

A I don't know. I would like to get in a halfway house like Delaware House or something like that.

Q How would you earn a living?

A I'm not sure because I know right now whatever income is my Social Security and if I can find something to live on that means, I would have to go back to the State Hospital.

Q Did you ever tie up the public phone on your ward?

A I've used it a lot, yes, I have.

Q Have people complained that you've been tying up the phone?

A Yes, they have. See, I am the one on the ward that was vocal. The other ones weren't vocal enough to be heard.

Q Have you had any long distance phone bills in

the past year or two?

A Yes, I have.

Q How large?

A About $1500.

Q For a month?

A No, for about a six-month period.

Q If you were released from the hospital today, would you continue taking medication?

A Well, I would take lithium, yes, I would, because I know right now that I have a problem.

Q Have you ever hit other patients?

A Only under duress.

Q What kind of duress?

A Well, it's a case where the ward violence was such that we're getting tensed up and something happened, happened in Ancora and you should do that and then, because of the locked environment, I have hit a couple patients but, not that bad, not much. They hurt me more than I have hurt them. I've been hurt quite a bit there at the hospital.

Q Have you ever hit any staff?

A What?

Q Have you ever hit any staff member?

A Maybe a punch or something like that or when they wanted to tie me up I would resist sometimes.

Q Do you know why you're in the hospital?
A Do I know why I am in the hospital.
Q Yes?
A I don't know exactly what you mean by that. I mean, you mean I'm mentally ill? I know that, yes.
Q What do you mean by that, mentally ill? What is wrong with you as you understand it?
A Right now?
Q Yes?
A They say I'm manic depressive, manic depressive insanity.
Q Do you agree with that?
A I don't know. I have heard so many diagnoses over five years from all kinds of doctors, I get confused by it all. When I first come in the hospital I didn't think I was ill. Then at the shock treatment I -- it, I had a problem with my memory. Then I recognized I had a problem.
Q Do you ever have delusions or hallucinations?
A At times my thinking gets a little off balanced, but, I don't believe I have hallucinations, no.
Q What do you mean your thinking gets --
A I get pretty high and start actively using my mind.

Q What do you mean by that?

A I, I keep thinking at fast rate.

Q Then what happens to you?

A Well, I keep talking and trying to solve different problems by taking educated guesses at things and make suppositions that sometimes might not be right.

Q Did you ever think you were somebody else?

A What?

Q Did you ever think that you were somebody else?

A Well, at times I have; yes.

Q Who did you think you were?

A Well, I thought I was -- at one time I said I was God because I found that he wasn't doing anything for me and I thought maybe I could do something for myself.

Q Do you think you are God now?

A No. I don't believe in God.

Q Do you think you are anybody else?

A Right now? No.

MR. WALLACH: If I might take a minute, your Honor.

I don't have any more questions.

THE COURT: Any redirect?

MR. GELMAN: Yes. A few questions.

REDIRECT EXAMINATION

BY MR. GELMAN:

Q Have you ever asked for juice to make the taste of the medicine more palatable?

A Yes, I have.

Q What happened?

A. Well, I asked for juice in my first hospitalization. I didn't get it. Recently in the last six months to a year I guess they have juice available on an irregular basis. Most times you don't get it, but sometimes the nurse feels like it she will send somebody down to the kitchen and make juice available.

MR. GELMAN: No other questions.

THE COURT: Mr. Rennie, how do you view Ancora?

THE WITNESS: It's a hell of a place.

THE COURT: Well, what do you mean? Expand more on it. In other words, you are in there. This is a place you are staying. How do you view it physically, from a social standpoint, from a treatment standpoint? Let me hear what your views are.

THE WITNESS: Well, for one thing, when I first got there all the buildings were identical. The stone work was all the same. It was all monotonous. Now, they have painted it up a little bit and changed it around.

From a social standpoint, when I

first got there there was no social contact with the opposite sex. I mean you couldn't go near the other buildings. There was no dances. Late last year it has changed. There are more dances. They have made one building, Cedar Hall fixed up pretty nice, but still it is a pretty scary situation to find yourself in.

When you come arytime there, their people that come there are generally lower-classed people. There are a lot of violent acts. You get brutalized.

THE COURT: How about from a treatment standpoint? What type of relationship do you feel at your point of view whether yourself or whether you can relate what the other patients feel? What is their relationship with we will say the medical staff?

THE WITNESS: Well, from my point of view, the doctor just used the medication to sedate the patients, to quiet them up. Any time an attendant thinks a patient is getting a little active or hurting themselves,

they talk to the nurse. They call on the telephone to the office and get a needle and get them quiet and tie them up?

THE COURT: Do you from time to time eat with your treating physician?

THE WITNESS: Well, I first came there they had more doctors. They had about three or four doctors on the ward. Then they had doctors made rounds in the evenings.

THE COURT: Do these doctors sit with you or talk with you or if you have a problem they will discuss it with you?

THE WITNESS: Just for a few minutes, not very long.

THE COURT: Say you are in the course of any one week, during a week's period of time, do you have any sessions with the psychiatrists or the doctors who are there?

THE WITNESS: Right now?

THE COURT: Right now or at any time that you were there?

THE WITNESS: The only time I had a session with the psychiatrist is when they gave me a treatment team and a schedule. Dr. Ortanez, I met with him. I had one 45 minute interview with Dr. Sugaoan a week.

THE COURT: How long did that last?

THE WITNESS: I think it was just a week or two.

THE COURT: Now, in terms of occupational type of tests, is there any activity going on?

THE WITNESS: You mean vocational?

THE COURT: Regularly during the course of the day that you could attend?

THE WITNESS: Activities?

THE COURT: Yes.

THE WITNESS: Job training?

THE COURT: Yes.

THE WITNESS: No job training whatsoever. There is no vocational rehabilitation on the hospital.

THE COURT: Well, what do they have? Do they have any games scheduled?

THE WITNESS: They have occupational therapy.

THE COURT: What type of games?

THE WITNESS: On the ward they sometimes bring up checkers and chess and they have pool and some wards have ping-pong.

THE COURT: Well, do you have anybody come in to instruct you on the games?

THE WITNESS: Sometimes they have and sometimes they don't.

THE COURT: Do you feel that your time during the course of the day is [illegible]

THE WITNESS: No.

THE COURT: Do you have a lot of free time on your hands?

THE WITNESS: Too much free time. Time in confined areas makes you really get heated and you get a little violent at times, I guess.

THE COURT: Well, do you feel that it would be a beneficial thing to you to have more to do during the course of any one day?

THE WITNESS: Yes, I do.

THE COURT: To be more regimentized?

THE WITNESS: Yes.

THE COURT: Do you know what I mean by regimentized? By having a set time to do certain things?

THE WITNESS: A schedule?

THE COURT: A schedule.

THE WITNESS: Yes.

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THE COURT: Is there such a schedule today?

THE WITNESS: No.

THE COURT: Give me your ordinary course of the day, what time you get up through the day. Take me through a typical day of yours.

THE WITNESS: Well, right now I get up, wake us up at 6:00 o'clock. At 6:20 we go to the cafeteria for breakfast. We come back. We have to lay on the floor or sit on the floor until they open the dayroom. They have patients who are retainer patients on precaution who are locked in the dayroom while we are going to breakfast in the cafeteria. So they have breakfast on the ward.

Then the doors are locked because they have to keep track of the spoons because they were used to open up the windows. They use to be able to open up the windows with them.

After the breakfast, there is medication at 9:00 o'clock. Then at 9:30 you are scheduled for OT, you go down to the

basement for occupational therapy for two hours.

I don't go to occupational therapy because I have been doing the same thing over and over and it gets to be monotonous.

THE COURT: What did they do at occupational therapy?

THE WITNESS: They do woodwork, leather lacing. They have coffee time at 10:00 o'clock.

THE COURT: You say you find it monotonous. Does that mean you are capable of doing something more complicated, more varied, more involved?

THE WITNESS: I would like to do something different. It is the same thing over and over again. I made about four or five chessboards out of wood. After a while, you want something different.

THE COURT: 9:30 would be occupational therapy?

THE WITNESS: Only if you have a referral. Maybe one percent has a referral.

Yesterday they only took down one person. When you stay in the dayroom up until

about 10:30, then it splits up again, two sections. One goes to the cafeteria. One goes to the dayroom for lunch in the ward.

After lunch you come back. The dayroom is locked again until that crew gets finished eating. You have to sit on the floor or stand around doing nothing until the dayroom gets open. They get medication at 1:00 o'clock. Then in the afternoon they lately been opening up the door to go to sleep until 3:00.

At 3:00 o'clock the next shift comes on and the doors are locked. Yougo back out into the dayroom. You wait till 4:30 for supper. Then you go back and the same problems with part of the people are locked in the dayroom. Some are locked in the hallway.

So after supper and then they open the dayroom up again andyou lounge around till 9:00 o'clock for medication. Then you go to bed.

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THE COURT: Do you have any television sets around?

THE WITNESS: We have televisions.

THE COURT: Are there any books around for people who may want to read a book?

THE WITNESS: No books. Sometimes there is old magazines that come around, but not very regular.

THE COURT: Do you feel if you were given a book, you would want to read a book?

THE WITNESS: Well, right now, with my memory being so poor, I have a hard time reading the long paragraphs.

THE COURT: You have difficulty in focusing your memory too?

THE WITNESS: Yes.

THE COURT: Now, suppose you were told that a certain medication would be good for you in helping your condition. Would you take that medication?

THE WITNESS: Well, in the past, I have tried all medication that the doctors had given me and then I didn't stop taking

then until the side effects got too much for me to bear. I then wanted to stop.

THE COURT: Have you ever been told what your underlying condition is? What may have caused it?

THE WITNESS: Well, not until I had Dr. Bugacan and she said I had a chemical embalance in my brain.

THE COURT: Is she the first doctor who ever told you that?

THE WITNESS: She is the first one who told me I had a chemical embalance.

THE COURT: Now Dr. Bugacan was in charge of your case, wasn't she?

THE WITNESS: She is in charge of the unit, yes.

THE COURT: And, would you from time to time meet with Dr. Bugacan and have sessions with her?

THE WITNESS: Yes.

THE COURT: Do you find it beneficial?

THE WITNESS: I don't know because she kept insisting on giving me prolixin which I don't want. She was a doctor that

forced the medication when I had an incident with the patient back in December, when they gave me injections of thorazine around the clock and put me on prolixin.

THE COURT: What is it that you want Ancora to do for you?

THE WITNESS: Well, I would like them to give me more say in choice of medication. If I am having undue side effects, they should bear with me and realize that I am a human being and that they shouldn't treat, they shouldn't treat me as an animal and force a drug on me, whether I want it or not.

THE COURT: Do you feel that there is an interest in you at Ancora as an individual?

THE WITNESS: No, I don't. I mean, from certain people there is, but on the whole, I'm just treated something that's just there to be housed, to be warehoused.

THE COURT: Do you want to be something more than warehoused?

THE WITNESS: Yes.

THE COURT: What is that you want to be?

THE WITNESS: I want to be able to get back out into the community; to be in a treatment program in the community where I can, if I need medication I can get that in the community and then, get involved in some kind of vocational rehabilitation where I can get job training so that I can get back to work.

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THE COURT: Now, do you recognize that as a part of what you want as you told me, that you would have to take a medication of some sort?

THE WITNESS: Yes.

THE COURT: Do you think that you could commit yourself to religiously taking such medication, even though you were outside the confines of the walls of Ancora? Do you understand what I mean, can you be trusted to take medication that would be good for you if someone were not standing over you making you take it?

THE WITNESS: Well, if I don't have any side effects that are bothering me, I'll take anything and in the past what I usually do is when the depressions got too bad, I would take more pills because the only thing the hospital told the doctor I was getting more depressed and all the doctor would do is increase the medication. So, when I got outside I was taking the pills and if I felt a depression coming on, what have you, I would take more pills.

THE COURT: I have nothing further.

Do you have any further questions as a result of my questions?

MR. WALLACH: Yes. I would like to ask one question.

Mr. Rennie, have you ever been referred for group psychotherapy with a psychologist?

A At Ancora?

Q Yes?

A I use to go but, when I said I dominated the conversation and so, they discontinued it.

Q Did they discontinue it or did you stop going?

A They discontinued it.

THE COURT: Anything further?

MR. GELMAN: Nothing further.

THE COURT: Thank you very much, Mr. Rennie. You may step down.

Anything further, gentlemen? Does this conclude the presentation of all your witnesses, Mr. Gelman?

MR. GELMAN: We have no other witnesses, your Honor.

XVII

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
CAMDEN, NEW JERSEY 08101

JOHN E. RENNIE,

Plaintiff,

CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI,

Intervenors,

vs.

ANN KLEIN, COMMISSIONER OF HUMAN SERVICES; MICHAIL ROTOV, DIRECTOR, DIVISION OF MENTAL HEALTH AND HOSPITALS; RICHARD WILSON, CHIEF EXECUTIVE OFFICER OF ANCORA PSYCHIATRIC HOSPITAL; MAX PEPERNICK, ACTING MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL; EDWARD WALLACH, ASSISTANT ADMINISTRATOR OF ANCORA PSYCHIATRIC HOSPITAL; AND JOSEFINA BUGAOAN, ASSISTANT MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL,

Defendants.

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TRANSCRIPT of the above captioned matter was taken before the Honorable Stanley S. Brotman, Judge, United States District Court, for the District of New Jersey, at the United States Courthouse, Camden, New Jersey, on Wednesday, June 13, 1979, commencing at 10:00 a.m.

* * * *

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THE WITNESS: Let me think -- no. This will be the first time.

THE COURT: Within the past year have you done any writings on this field?

THE WITNESS: Yes, I did write a paper. I don't know if it's going to be published or not. I wrote this paper for a meeting on Tardive Dyskinesia held at Syracuse last year.

THE COURT: Did you present the paper at that time?

THE WITNESS: Yes.

THE COURT: I find the witness to be qualified. Let's proceed.

BY MR. GELMAN:

Q Doctor, have you performed in the last two days surveys of patients in New Jersey State Hospital?

A Yes, I did.

Q Ancora and Marlboro Hospitals?

A That is correct.

Q What were you attempting to accomplish in these studies?

A What I was trying to accomplish was to find out whether there were any cases of Tardive Dyskinesia or any other neurologic disorder of any clinical significance in these two hospitals. I wanted to know how well these

cases, if I did the exam and documented it and what kind of recommendations were made as far as the general management of those cases were concerned.

Q Briefly, how did you go about performing that survey?

A I did more or less use the approach I used in other hospitals. As I said before, I made many surveys in, in hospitals that are part of a research system but also made surveys in other hospitals because -- at the request of various agencies and also I made a survey, two surveys, one in Italy and one in Sweden and one in Turkey.

Now what we did was to select certain wards and I must say in fairness to the hospital administration, that we focused on patient populations that were likely to have the disorders, namely chronic patients who had been on drugs for a long time and particularly geriatric cases because we know now for certain that the older the patient, the more likely he is to have some sort of permanent neurologic disorder. If I'm going to give you, if you ask me to give you some figures on the incidents of disorders I found, certainly it does not reflect the total prevalence of the disorder because we focus on populations that were likely to have the disorder.

Now we, what we hope to do what to do, walk into

a ward and select a ward and pick up a random sample, mainly the majority of the patients of a ward and see them all and then after all the patients were seen or rate every patient or neurologic disorder if any and then get an appropriate idea of the prevalence. Unfortunately this could not be done very systematically because of the nature of the survey. We were supposed to visit these patients without previously having been previously arranged. It was sort of a surprise-type of an evaluation.

Now because of this, the patients, not all patients were on the ward. Incidentally, we did not want to interfere with the patients. That was our understanding. We did not interfere with their therapeutic program. Then we did not have a list of the patients. However, we got considerable cooperation from the personnel in both hospitals and were able to see most of the patients on three or four wards. In addition, I was asked by you and by another member of your organization to see certain patients who were of particular interest. They were not part of the survey because they were selected for evaluation because of certain problems that were under investigation. There were about ten patients belonging to that last category.

There is another condition that is called

THE COURT: You're the keyman. If these findings are yours, then I would prefer you using the word I.

THE WITNESS: All right. The findings are mine and I could arrive at those conclusions with the help of those various people I mentioned before. Anyway, so I will talk in the first person.

BY MR. GELMAN:

Q I examined 99 patients. Why not 100 is just because there was a little discrepancy in the records. Well, 99 patients were from, I think, four wards and most of those patients were geriatric, over 65 years old, and I have the following findings: I divided my physical findings into one, two, three and four because this is the classification of the AIMS; namely, one means minimal; two, moderate, three,moderately severe; and four, severe.

THE COURT: These are the classifications of whom?

THE WITNESS: That's the classification of the rating scale, the AIMS.

THE COURT: American Institute for Mental Studies?

THE WITNESS: No. That particular

scale was developed by the National Institute of Mental Health.

THE COURT: All right.

THE WITNESS: It's a simple list of symptoms and, according to various regions of the body, much of the emphasis is on the head because most of the symptoms appear in that area and each symptom is then given a rating from zero, absence, to four, very severe. This is the breakdown. Minimal -- and this is Tardive Dyskinesia. Only minimal, nine cases; moderate, thirteen; moderately severe, five; severe, four.

The minimal symptoms are really of very little clinical significance. The latter symptoms might not be very significant because they really don't cause any distress in the patients, but they are important because if medication is continued, they might get worse and the rating might go up from two to three and four. Then I also looked at other symptoms; namely, Parkinsonism, and I found twelve patients who had some evidence of Parkinsonism, namely tremor of the hands. That was the obvious symptoms. Three patients had both Tardive

Dyskinesia and Parkinsonism. Then there was one patient whom I could not identify but I put him down as a classification anyway.

Out of 99 patients, 49 patients had some sort of diagnosable neurologic deviation.

THE COURT: Comprised of Parkinsonism and Tardive Dyskinesia?

THE WITNESS: Yes. Those two things, there were 49 or roughly half of them. That seems to be an enormous figure, but really it is not greater than that in other hospitals I surveyed.

THE COURT: Now, does your survey note how long each one of these persons have been on, psychotropic medication?

THE WITNESS: We don't have -- because of shortage of time, I don't have the exact information. The only things we checked --

THE COURT: Wasn't that important?

THE WITNESS: That would be extremely important, so the only thing that we checked, whether or not the patient had been on some sort of neurolyptic medication for any length of time. Of the 99 patients, there was onlyone patien: for whom we could not get this information and

I did not include this patient in the Tardive Dyskinesia group. He might have gotten the medication but this was in the records, of course, not available to us, and adequately -- I mean, I was reasonably well satisfied with the fact that they had received sufficient medication to cause the symptoms. Probably they had much more than that was in the records, so that was the minimum. And with that drug history, I would say a patient was a candidate for, neruologic disorder. Of course, we did not include a few patients who had received medication only occasionally but most patients had received medication for a lengthy period of time and many were still on medication. The fact that some patients were on no medication does not invalidate the diagnosis of Tardive Dyskinesia because it consists for many years after it is discontinued in typical cases.

Now, I thought it would be important that I give you some details on a number of patients who were in class 3 and 4; in other words, severeand very severe o. moderately severe and severe, and if I may, I would like to demonstrate what I consider severe in terms

of disorder of the mouth and I think I can imitate it.

THE COURT: See, you can imitate it but in order for the record to show it, we have to describe it.

THE WITNESS: Okay.

THE COURT: So you'll have to do both.

THE WITNESS: I'll do both, sir. Yes, sir. Moderately severe in the mouth would be a condition that is very visible, includes the protruding of the tongue out of the mouth; constant movements of the jaw, usually side by side, and other movements of the lips and teeth. Now, I think I can demonstrate it. Something like that. This, I would say, is moderately severe.

Very severe would be -- involve a marked protusion of the tongue and a greater number of movements in the general area. So if his movements are extremely severe, usually the patient also moves the neck, the head, any other part of the face. I was in no position to decide whether or not these -- these type of movements really interfered with eating, swallowing, or phonation -- phonation means

articulation of the words -- for two reasons because I did not test the patients for this condition and because many of the patients would not describe the symptoms, due to the advanced state of mental deterioration.

Now, if I may --

THE COURT: Did you find a direct correlation between the advanced state of mental deterioration and the Tardive Dyskinesia?

THE WITNESS: Usually there is a correlation and I made some studies to the effect and I presented some of the data at the recent meeting. Patients who were very severely deteriorated and a certain sub group of patients who are severely deteriorated have more Tardive Dyskinesia, but I don't know whether this is due to the mental deterioration or to the fact that severely deteriorated patients have been in the hospital longer and are usually exposed to more medication. That's an important question and, unfortunately, I don't have an answer. I did spend about two years on this particular problem and I didn't come out with a definitive answer.

Parkinsonism, as I said, was present in twelve patients and both conditions in three. In some, peculiar clinical manifestations were present in three patients. Now, I have a list here of, I think, it's ten patients. I identified them by numbers and all those patients either had severe or moderately severe dyskinesia or some very serious condition of a neurological type, and I give you a very brief description. I mean, I can now indicate whether or not they were on drugs, what type of record -- what type of note did appear in the record concerning this condition. I have this information here.

MR. GELMAN: Excuse me, Dr. Crane, if I can interrupt. The defendants, Mr. Wallach, has a list which has been correlated with ours and we'll give him the name of the patients from the number Dr. Crane uses so that he'll be able to follow.

THE WITNESS: This information I'm going to read now is based on the information that I received in examining the records. There might be some inaccuracies but I think they're basically correct.

Patients who on no current medication. There was no diagnosis of Tardive Dyskinesia. Now, all these patients that I'm going to report on now had at least moderate dyskinesia.

Patient 18, no medication and AIMS was in the record, indicated some dyskinesia but no indications that the tongue was affected, although that was the most conspicious symptom.

Patient 40, no medication, no current medication; no pathology reported. By pathology meaning presence of neuro symptoms.

Patient 42 on seven milligrams of Navane. No pathology reported.

Patient 43, fifteen milligrams of Navane a day, no pathology reported.

Patient 44, Navane seven milligrams currently administered. There was a neuro consultation or a few neuro consultations indicating that this patient had defused involvement but there was no discussion of a possible defarential diagnosis with Tardive Dyskinesia. This patient was severely disabled.

Patient number 50, Thorazine, 100 milligrams a day. No neurological disorder reported.

Patient 54 on no medication but no Tardive Dyskinesia reported.

Patient 55, he was getting Edifron, four milligrams of Trilofon because it has two components, two milligrams of Trilofon three times a day; severe neurological involvement; no discussion of a differential diagnosis with Tardive dyskinesia.

Patient 73, no neurologic findings reported.

Incidentally, on two of thosepatients we have a TV -- what you call it? As it was seen on TV.

THE COURT: What?

THE WITNESS: Seen on television.

THE COURT: In other words, you've made a TV video tape record. Is that correct?

THE WITNESS: Of two of those patients and you have the numbers of them. I don'tknow which ones they are, but that's unimportant, I think now.

I don't have a detailed description of what was being done for the patients who had Parkinsonism. Most were on current medication and there was very little description of

Parkinsonism, although this is a condition that can be ameliorated greatly by reduced medication or discontinued medication.

THE COURT: These are all patients over sixty-five?

THE WITNESS: No, sir. Majority are. I don't have the exact -- I mean, I have -- it is in the record there. I would say most of them were over sixty-five. In the other hospital I have the information on the records, but this information can be easily obtained.

THE COURT: All right.

THE WITNESS: Now, I did see three patients at the request of Mr. Gelman because there was some problem with them and I would like to say briefly something about these patients and also here I'm going to give the code number.

Patient 56, a patient of age sixty had a variety of symptoms, very obvious ones, and this particular patient had, I would consider it as -- each condition being moderately severe, but since he had various parts of the body involved, I would say the condition was -- well, at least -- at least severe. He was receiving

currently Thorazine, one hundred milligrams three to four times a day. The physical on admission, April 16,1979, reported no neurologic findings, and I can assure you that the symptoms could not have developed in one month.

MR. SCHWARTZ: Objection. There's no foundation in the record. I realize that he's an expert witness, but there's no -- he's assuming facts that are not in evidence as to what may have transpired in the month, and I think it goes beyond his testimony to testify what could have happened in a month as to this particular patient. The doctor --

THE COURT: I'm going to overrule you. I'm going to allow it. He certainly is qualified as an expert in this area and he certainly knows what times it takes for certain things to develop and he's going by what he finds in the record and certainly I think he's qualified to make that observation. I will allow it.

THE WITNESS: Thank you, sir.

There were no findings pertaining to the neurological question on admission and there was an AIMS, which was found negative.

THE COURT: I may doubt this. If there

were no findings on admission, that may have been a deficiency on the admission procedures. The Court recognizes that, too. That's part of this suit, also.

You may continue.

THE WITNESS: The other patient is number 57. This patient received heavy medication in the past and he is well known to Mr. Gelman. Apparently he was on Lithium and apparently this medication is very helpful and as far as we know, Lithium does not have any effects on this neurological disorder.

MR. GELMAN: Dr. Crane, you can identify this patient by name.

THE WITNESS: This patient is Mr. Rennie.

THE COURT: I assumed that, naturally. You may continue.

THE WITNESS: Well, I don't have to repeat the fact that at one time he was on very heavy medication. At the present time he was on Lithium and I'm not going to discuss the merits of this medication and I think we all agree that Lithium seemed to be quite helpful. I don't think that Lithium has much of an effect on his neurological condition, although in rare cases it might influence it either favorably or

unfavorably and I was interested in detecting some evidence of mild to moderate dyskinesia of the lips.

THE COURT: Did you find that?

THE WITNESS: Yes, sir. As the patient apparently was not aware of it, certainly I can say that it did not -- it was not of such a condition to bother him, but I observed it, for what it's worth.

BY MR. GELMAN:

Q If I may, Dr. Crane, from examining him on the day you did, are you able to determine whether two months ago this condition was more or less severe?

A I'm not.

A third patient is coded 102. He's a patient age fifty-three and, according to the diagnosis, he has a depressive condition and my brief contact with him would indicate that the diangosis is certainly correct. Now, I observed in this case a severe dyskinesia of the jaw, a slightly less severe dyskinesia of the tongue, very active movements in the upper extremities, lower extremities, and some musculature of the body, very distinct movements, of the diaphram, and there was a certain difficulty in walking. He was by no means disabled. I don't want to give that impression, except

insofar that the patient was extremely embarrassed by this condition, and in this sense, it caused some disability. We saw -- we checked the record and the record indicated that last summer or about, I think it was about July 17th, '78, a diagnosis of Tardive dyskinesia had been made and a recommendation was made to discontinue medication because of this diagnosis. Since then we noticed that he had received Navane and Haladol, I think. I'm not sure that he was on Navane currently. Now, the AIMS did not reveal any pathology.

This covers my observations at Ancora State Hospital.

THE COURT: All right.

THE WITNESS: I think I would like to proceed now to the Marlboro State Hospital.

THE COURT: Saving you the trouble of asking questions, Mr. Gelman.

BY MR. GELMAN:

Q Please.

A It's at Marlboro State Hospital we did something similar to what we did in Ancora and we saw -- I'm sorry, I saw fewer patients, sixty or fifty-nine, down there and the reason was that we had -- they were spread out. Many patients were not confined to the wards and the wards of younger better integrated patient

were almost empty. I saw fewer patients there and I thought that the number was sufficient for our purposes.

THE COURT: It was a less crowded institution than Ancora?

THE WITNESS: Yeah, it was -- I don't know. I would say, I mean, if I can make my remarks, that most hospitals impress me very favorably in terms of the lack of being overcrowded and general care thatthe patients were receiving and the cleanliness of the place and the spaciousness in general of the place. This impressed me very favorably.

Well, anyway, I'm going to talk in the first person. I saw 58 patients on a survey and, in addition to that, I saw, I think, two patients. Actually, I saw six patients at the request of a member of the Advocate's office. Here the picture was not much different and I didn't expect it to be much different because what I found in Ancora I found it in most State institutions.

Now, of sixty patients, a total of twenty-eight, again roughly one half, had some neurological disorder; two minimum dyskinesia, nine moderate dyskinesia, four moderately severe,

one extremely severe. There were four patients with rather pronounced Parkinsonism -- no, I'm sorry, four patients with Parkinsonins alone, from mild to moderate; seven patients had both Tardive dyskinesia and Parkinsonism; four of them rather seriously disabled. There was one patient who had what appeared to be dyskinesia, but we could not ascertain whether he had ever been on medication. All the other patients were either on medication or had been on medication. So in other words, the condition -- their medication was sufficient because Tardive dyskinesia and, of course, I must also say that thirty patients were negative.

Now, here I have a list of, oh, about twelve patients who had a rather severe or very obvious neurologic condition.

Patient four, generalized tremor and thatpatient was on Serentil, two hundred milligrams a day; no evidence in the record of this condition.

Patinet nine had both dyskinesia and tremor. The current medication was Prolixin intramuscularly, I think, once a week plus Prolixin twenty milligrams a day plus Akinaton.

This patient, in addition to dyskinesia and tremor, seemed to me to have possibly some other neurologic disorder. At least, I would have suggested a neurologic -- an updated neurological evaluation. There wasn't anything of that sort in the record and that diagnosis was schizophrenia catatonic type. I don't know if the patient had a neurological condition, a naturally occurring neurologic condition and Tardive dyskinesia or both, but the record did not indicate anything having been done to clarify this problem, at least not in the last couple of years.

Patient twelve had Tardive dyskinesia of the tongue, medication Meladril, fifty milligrams, which is a small dose, but for an elderly person sufficientto cause some neurological disorder. Nothing in the record concerning the neuro condition.

Patient thirteen, dyskinesia of the mouth and this is all at least moderately or moderately severe. No medication currently; medication in the past. Nothing about a neurologic condition.

Patient sixteen, dyskinesia of the mouth,

moderately to moderately severe. I don't know if it was on current medication or not. It was not clear in my record. He had previous medication; nothing in the record about a neurologic condition.

Patient seventeen, same thing about dyskinesia of the mouth, Haladril, two hundred milligrams a day; no indication of any neurological disorder.

Patient eighteen, dyskinesia plus tremor Sekontial one hundred milligrams a day. Nothing in the record about the neurologic condition.

Patient thirty-four, at least moderate Parkinsonism, receiving two hundred milligrams of Thorazine, which is relatively high in a patient age sixty-six and also Prolixin IM -- please leave that out. I'm not sure here. I think, but I'm notsure.

Patient thirty-seven, Parkinsonism, receiving now Halodal, twenty milligrams, which is a very high dose, particularly for a patient sixty-one, and this patient had Parkinsonism. Nothing in the record about this condition.

Patient forty-nine, for whom I know we have a TV record, but I can check in Imbex,

extremely diffused dyskinesia, totally disabled and AIMS was in the record and the AIMS appeared to be negative.

Patient fifty, dyskinesia of the tongue, moderately or moderately severe, receiving fifty milligrams of Melaril. Nothing in the record about his neurologic condition.

Patient fifty-three, dyskinesia, tremor, and a large number of symptoms, not only in the mouth but in the whole body so that the patient had a very bizarre gate and very conspicious motor abnormality. On admission, the patient had been put on Halodal, fifty milligrams DAD. This was discontinued and he received -- he is receiving now Lithium, which I think is justified because the patient is an old manic depressive. The only thing that was noted was in one note that the patient had tremor, but nothing about Tardive dyskinesia. and his very diffused symptomology.

I was asked to see six patients who were known to be [illegible] vocate's organization to see what my feeling was. I must say that the ways the six patients, four had no neurologic symptoms and I did not make any judgment as to

Q Were you surprised to find that Ancora and Marlboro these conditions had not been charted insofar as you could tell?

A I can't make a general statement. I was not surprised on the basis of my experience in previous hospitals.

THE COURT: What kind of hospitals?

THE WITNESS: Various state hospitals. Some of them I was associated and others I just made a survey.

THE COURT: In other words, you're making a distinction now between State hospitals and private hospitals?

THE WITNESS: Oh, yes, yes, I have very little experience with private. Most of my experience is in state institutions.

BY MR. GELMAN:

Q But in your experience in the different states, this failure to note side effects or Tardive dyskinesia is wide spread in state hospitals?

A That has been my experience. The last survey I made was two years ago in California.

Q Do you have an opinion as to why that is so?

A Well, I can speculate. There was strong opposition on the part of the medical profession

industry and also government agencies, although the agencies are very reluctant to accept Tardive dyskinesia being a serious problem, this has more or less persisted at a lower level.

Q What basis do you have for saying that?

A Well, I had many discussions with prominent clinations in academic circles and for the first few years, until 1971, '72, they denied the existence as a disorder or felt the disorder was unimportant. In '71, '72 steps were taken, the Food and Drug Administration sponsored a meeting at which I participated. Most drug companies changed the package insert to include a section on Tardive dyskinesia. It means that for six, until '71, '72 the physicians had very little information on this disorder, although there were by then at least a couple hundred articles on this disorder. But the package insert didn't have information and the Food and Drug Administration did not send any letters that they usually do when physicians have to be alerted to hazardous conditions. But after '72, not only was the package insert adequately covered as far as Tardive dyskinesia was concerned but a number of articles in scientific journals and the American Journal of Psychiatry, that it's very readily available, a number of articles, the number of articles increased.

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Q In your career, Dr. Crane, have you tried various means to effect the prescribing practices of state physicians and their recording practices?

MR. SCHWARTZ: Objection on the grounds of relevancy to this particular case. What is past evidence in the field may or may not relate to his experience in that which he is testifying with respect to the present lawsuit.

THE COURT: Mr. Gelman.

MR. GELMAN: The defendant, one of the defendants main contention is that the existence of a science of psychiatry and the use of the trained psychiatrist provide adequate safeguards against undue side effects and against unnecessary infliction of pain. I think it is relevant to show for whatever reason that science is like every other human activity and can be assisted if we are interested in pinpointing certain things that are important because of a legal interest.

THE COURT: Does that fall within his expertise here, what he is called upon to testify to?

MR. GELMAN: Dr. Crane personally had a role in these events. For example, the Court

that?

THE WITNESS: Because the -- a patient might get much better on a certain dosage but the patient might have improved on much less medication. So medication would have to be manipulated several times just to make sure that this was not a coincidental change in the patient's behavior and mental condition.

Individual clinical case histories are very uninformative because each patient reacts differently. That's why one needs random samples, large samples, systematic sizes, comparing people with placebo and people on drugs and other studies have been done at the National Institute of Mental Health and both studies, both acute and chronic population, indicate that medication is helpful in schizophrenia. There's no doubt about it.

But the important thing is not to exceed certain doses. Because there is -- a medication has accumulative effect. If you start very high at the beginning of treatment, unfortunately many conditions just ignore very high, it is accumulating the organism. And the patient might receive very high medication and do well when

he could do much equally well on a third of the medication but a lot of the medication has already done some damage to the central system, might be a systematic. Four or five years later, the patient might need a course of medication and the doctor might give the amount of -- will Tardive Dyskinesia but the organism has -- was already exposed to the insult of medication, which was probably unnecessarily high. But most important at all is the monitoring. See what happens to the patient.

At the meeting of Syracuse, we had a discussion, how often should the patient on chronic medication be seen? In many institutions, I know in Maryland and NOrth Dakota, and I'm pretty sure also California, medication has to be renewed once a month. Unfortunately, in many cases, a renewal of medication means having a stack of medication records on your desk and signing them over. Now, obviously, this perfunctory activity defeats its purpose.

I would assume the physician who renews the medication would see the patient and decide what to do. Ask at least a few questions and find out whether the patient needs continuation

of medication or needs different medication or whatever. That is the purpose of renewal of medication.

And when the physician sees the patient for the purpose of renewal, all he has to do is just take a quick look at the patient and he'll know whether or not if Tardive Dyskinesia is developing because once it is there, we have no treatment for it and one has to take certain steps that absolutely necessary to prevent a worsening of the condition. A mild Tardive Dyskinsia sometimes cannot be avoided and certainly is a type of risk one can take because of the benefits the patient gets from the drug.

BY MR. GELMAN:

Q Do I correctly paraphrase your opinion to say that each person can safely receive a certain amount of neuroleptic drugs over his lifetime and that the use of the drugs early restricts therapeutic opportunities later?

A That's very well put, sir.

Q Thank you. Is it your opinion then that with attention to dose levels and monitoring, that neuroleptic drugs can be used with an acceptable level of risk?

A Yeah. The important thing is acceptable level of risk.

Q In your opinion, is the level of risk created from prevailing practices and acceptable level of risk?

A Certainly not because of the extremely large number of patients with side effects of a permanent nature.

Q Do you know of any predences in modern medicine for the wide spread use of agents which produce this much toxicity?

A I don't think there's any precedent.

Q You believe that toxicity is unnecessary?

Q Well, there is no precedent, not only in terms of -- well, there might be precedent in terms of toxicity, but there's no precedent in terms of the medical profession ignoring this particular problem.

For instance, we have anti cancer drugs which are extremely toxic, certainly more than neruoleptics but everybody knows about it. It's a patient -- the administration of those drugs is given with extreme caution because of their terrible side effects that it causes.

Q Dr. Crane, in your view of the charts, did you notice the use of weekend drug holidays, drugs would not be given for two days?

A I didn't pay particular attention to that at either hospital.

Q Is that a recognized practice in psychiatry, a short drug holiday?

A It is a recommended practice. Unfortunately, nobody has -- takes the troule of defining what a holiday is.

Q Do you have an opinion about the usefulness of a drug holiday that's two or three days long?

A It won't hurt unless the medication is not increased because the patient's not going to get it for two or three days.

I -- frankly, if you ask my opinion, it's -- as a clination, I would prefer for the patient to have -- to have it everyday, except injectable form, but in very small doses and there is one reason too, one medical reason, that if a patient has been off drugs for three or four days, because sometimes a patient takes three or four days to visit families, acute tolerances for acute side effects may cause, for instance, a drop in blood pressure is a very fleeting side effect and after three or four days of medication, he goes away, but if the patient is on no medication for three or four days, he might again be sensitive to the effects of drugs or the blood pressure regulating mechanism so that would be

one of the reasons why I would not discontinue it for any length of time.

However, according to some physicians, a drug holiday is a vacation that might last two or three months to see how the patient is doing without medication and I'm all for it.

Q You testified about finding AIMS surveys in the hospital charts?

A In Ancora State Hospital, I saw practically ever chart had an AIMS form in it.

Q Was the AIMS form always filled out or was it there in blank?

A Some were blanks. I assume they hadn't gotten around to filling it.

THE COURT: Any notations on those charts of treatment plans for these individuals? Did you notice any notations on the treatment plan had been filled up?

THE WITNESS: I am familiar with treatment plan procedures. It -- I think, yeah, in Marlboro, they had some sort of team work that apparently the purpose of which was to -- for each member of the team to make some plan or make some decision. I think that is what observed in Marlboro.

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XXIII

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
CAMDEN, NEW JERSEY
CIVIL ACTION 77-2624

JOHN RENNIE,

Plaintiff,

vs.

CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI,

Intervenors,

vs.

ANN KLEIN, COMMISSION OF HUMAN SERVICES; MICHAEL ROTOV, DIRECTOR, DIVISION OF MENTAL HEALTH AND HOSPITALS; RICHARD WILSON, CHIEF EXECUTIVE OFFICER OF ANCORA PSYCHIATRIC HOSPITAL; MAX PEPERNIK, ACTING MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL; EDWARD WALLACH, ASSISTANT ADMINISTRATOR OF ANCORA PSYCHIATRIC HOSPITAL; and JOSEFINA BUGAOAN, ASSISTANT MEDICAL DIRECTOR OF ANCORA PSYCHIATRICT HOSPITAL,

Defendants.

STENOGRAPHIC TRANSCRIPT OF TESTIMONY

TRANSCRIPT OF THE ABOVE-CAPTIONED MATTER WAS TAKEN BEFORE THE HONORABLE STANLEY S. BROTMAN, JUDGE, UNITED STATES DISTRICT COURT, FOR THE DISTRICT OF NEW JERSEY, CAMDEN, NEW JERSEY, ON TUESDAY, JULY 17, 1979, COMMENCING AT 9:30 A. M.

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rather than a legal nature.

MR. WALLACH: Thank you very much.

THE COURT: Any redirect or cross? You have the right to do two things.

MR. GELMAN: Thank you.

BY MR. GELMAN:

Q Dr. Crane, Mr. Wallach asked you about your rating scale for Parkinson symptoms. Did you see any rating scale comparable to the AIMS in anybody's chart, to look for a Parkinsonian symptom?

A I did not see a scale. Occasionally, very occasionally I saw Parkinsonism mentioned in a weekly or monthly note.

Q Now, Dr. Crane, if you had had more time to examine patients, is it possible you would have found more pathology?

A It has been my experience that pathology is often overlooked if not enough time is given in examination of patients.

Q So generally the longer the neurological examination, the more pathology is found?

A Yes. I would qualify that. Unless I make an error, I might overlook minor pathology of little clinical significance. That has been my experience when in the past I saw a patient and was, saw the patient

and early '70's there were reports by psychiatrists finding very low incidences of tardive dyskinesia or no instances of tardive dyskinesia in hospital populations, state hospital populations?

A The earlier reports, many earlier reports show a very low incidence or no tardive dyskinesia at all.

Q Before the FDA acted in 1973, would you say the general, not academic psychiatrists, but the clinical psychiatrists, their diagnosis of tardive dyskinesia was extremely rarer and not a serious prescribing problem?

A I would say in 1971 and '72 was a turning point.

Q In 1971 and '72 you were working on state hospital wards or did you have access to them?

A I did, Springfield Hospital Center in Maryland.

Q Had you been on other state hospital wards?

A Prior to that I had an opportunity to visit six other state hospitals that were included in a research project sponsored by the National Institute of Mental Health.

Q Wasn't the pathology that we identify as Parkinsonism and tardive dyskinesia obvious in those hospitals?

A It was very obvious to me.

Q How could it be that the psychiatric concensus and understanding of people who worked in psychiatric hospitals was that the condition was extremely rare?

A I cannot answer the question except that it's one of the mysteries of current psychiatry. That's all I can say. I have my own opinions but I'd rather not talk about them.

Q You put me in a sensitive position, Doctor.

THE COURT: Afraid to ask the question?

MR. GELMAN: Pardon me?

THE COURT: Afraid to ask the follow-up question?

MR. GELMAN: Yes. Dr. Crane, I brought Dr. Crane in from across the country and from over the ocean.

Q Dr. Crane, would you say that the prevailing level of psychopharmacology in the hospitals is extremely bad with respect to preventing neuroleptic drugs causing damage to people?

A I can only talk about the hospitals that I have seen. Although I am pretty sure that it would be generalized but I'm willing to talk about three hospitals, the one in North Dakota, in Jamestown, North Dakota, which I was clinical director, the Springfield Hospital Center in Maryland and that hospital in California, the

Q What extent do you think the state physicians overlooked tardive dykinesia and more subtle problems resulting from the fact that the patients had no choice of physician; they have no free choice --

A I don't think I can answer this question.

Q Do you know of any precedent in the history of medicine where physicians acting or "treating" patients who had no choice as to physician and where the physician had no choices whether he or she wanted to treat the patients?

A This is two questions. As far as the first question is concerned, I would say in medical practices the patient has no choice and the fact is the physician might be forced to treat a patient. That's an interesting question.

Q Can we just assume that the ethical considerations and considerations of concern for the patient which motivates physicians and in usual circumstances will also motivate them in this forced situation?

A I would say tentatively, yes.

Q Is that a hope or a belief?

A Well, it is a hope.

Q Dr. Crane, if legal procedures succeeded in having patients' complaints taken seriously and having matters aired despite the attitude of the patient to

the physician and the physician to the patient, wouldn't that be a medical and humanitarian advantage despite the legal guise?

A It certainly would. I think if a patient gets the proper treatment he automatically, his rights are protected. A good medicine means good protection of the patient's legal rights.

Q Well, Dr. Crane, your medical ethics apparently give very heavy weight to tardive dyskinesia. But isn't it true the records of psychiatry is that other psychiatrist's ethics believe if they given heavy weight to that, they're not that concerned about it?

A Unfortunately, yes.

Q Well, why would it be so bad if the courts made a social judgment which happened to coincide with your medical ethics which was that tardive dyskinesia was in fact serious?

A That would be very helpful.

Q You agree that at least in some circumstances each physician should not be permitted to have, to give free rein to his moral convictions on this score, whatever they are?

A Understanding the questions, yes, I would. When it comes to the specific case of tardive dyskinesia.

Q There is enough evidence to support your statement

you've lectured to physicians on tardive dyskinesia?

A Many times.

Q Have you gotten any reaction from the psychiatrist or physicians you've lectured to? Have they come up after you spoke or lectured later about it?

A Well, the reactions that physicians -- to my lectures or to my presentations were either wishy-washy or revealed a lack of understanding in many instances.

Q Has there ever been a psychiatrist who has come up to you and said, did say though this Dr. Crane we need those drugs or anything to that effect?

A They said something to that very often to that effect, something to that effect.

Q Do you believe that the recognition of the problems and seriousness of tardive dyskinesia is a regress -- I mean difficult psychotropic problem or was it something that really nature pretty much handed up to the profession as obvious?

A Well, I would say the diagnosis and recognition of the disorders are not difficult medical problems. The management of the condition is a difficult problem and sometimes a physician has to make a difficult decision whether the risk of side effects outweighs the possible benefits.

Q Well, now, is the patient well served if the

physician who is making that judgment believes that tardive dyskinesia is an acceptable price to pay in all cases?

A It is not an acceptable price to pay. It might be acceptable in a small case. It might be acceptable price to pay only in rather a small number of cases. I would say it's the exception rather than the rule.

Q That's in your opinion --

A In my opinion, yes, of course.

Q We had a psychiatrist testify earlier here that schizophrenia was a life-long emergency and that drugs to treat schizophrenia if they cause tardive dyskinesia were still an acceptable procedure. Would a patient be well served if that physician with his particular weighting of risk and the benefits was the treating physician --

A I answer definitely no. It would not be well served.

Q Doesn't it seem that a lot of psychiatrists who work in state hospitals have exactly that?

A I cannot answer the question. I would have to pass judgment on individual cases.

Q Doctor, if a physician indicates that on a chart that a patient has tardive dyskinesia might be not feel he's admitted wrong doing or medical

mismanagement?

A Can you rephrase the question, please?

Q Let me ask you this. Do you think one reason why tardive dyskinesia is not diagnosed on charts is that the physician is concerned about incurring liability for the condition?

A Conceivably, yes, conceivably.

Q Is it also possible the physician is concerned if he makes the diagnosis of tardive dyskinesia and puts it in the chart, that that diagnosis will preclude him from using the drugs in the future? He doesn't want to give up that option?

A That is probably true because the package inserts include a fairly defined statement to the effect that drugs might have to be discontinued if a patient has tardive dyskinesia.

Q Do the package inserts also say that increasing the dose of neuroleptics or shifting to a different neuroleptic may cause an abating of symptoms?

A I think that the material at least in one drug company which is Sandoz has something to that effect.

Q Incidentally, Dr. Crane, if all patients on the, say, Ancora Geriactric Service were taken off neuroleptics, isn't it likely that more tardive dyskinesia

would be found because of insipient -- isn't tardive dyskinesia masked and it would resolve itself?

A Probably they would pick up a few more cases.

Q In reforming or attempting to remove or change a hospital's neuroleptic prescribing practices, do you think that outside scrutiny would be helpful, outside consultants and so on?

A If outside consultants were qualified, I would say yes.

MR. GELMAN: I have no further questions.

THE COURT: Anything further?

MR. WALLACH: No questions.

THE COURT: Thank you very much, Doctor. You may step down.

THE WITNESS: I'm excused?

THE COURT: You're excused.

THE WITNESS: Thank you, sir.

THE COURT: Do you want a further witness before lunch or shall we break for lunch now?

MR. GELMAN: It would be good to break now.

THE COURT: We will recess now to resume again at 1:15.

(At which time the court stood in recess.)

# Appendix 3

81-5534

NO.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

JOHN E. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MAY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

PETITIONERS,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

RESPONDENTS.

APPENDIX H, PART 2, TO PETITION
FOR WRIT OF CERTIORARI

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On the Petition

XVIII

UNITED STATES DISTRICT COURT,
DISTRICT OF NEW JERSEY,
CAMDEN, NEW JERSEY 08101

CIVIL ACTION 77-2624

JOHN E. RENNIE,

Plaintiff,

CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MARY MC GRATH, JOSEPH KAMIENSKI,

Intervenors,

vs.

ANN KLEIN, COMMISSIONER OF HUMAN SERVICES; MICHAIL ROTOV, DIRECTOR, DIVISION OF MENTAL HEALTH AND HOSPITALS; RICHARD WILSON, CHIEF EXECUTIVE OFFICER OF ANCORA PSYCHIATRIC HOSPITAL; MAX PEPERNICK, ACTING MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL; EDWARD WALLACH, ASSISTANT ADMINISTRATOR OF ANCORA PSYCHIATRIC HOSPITAL; AND JOSEFINA BUGAOAN, ASSISTANT MEDICAL DIRECTOR OF ANCORA PSYCHIATRIC HOSPITAL,

Defendants.

HEARING ON PRELIMINARY INJUNCTION

COPY

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TRANSCRIPT of the above captioned matter was taken before the Honorable Stanley S. Brotman, Judge, United States District Court, District of New Jersey, Camden, Tuesday, July 10, 1979, commencing at 9:30 a.m.

* * * *

Appendix H, part 2 88k

Q Do you have a daughter?

A Yes, I do.

Q Has your daughter had any connection with Marlboro Psychiatric Hospital?

A Yes, she has.

Q When did that begin?

A I'd say about a year -- a year ago was the first time she was there.

Q What is your daughter's name, please?

A Terri, T-E-R-R-I, Patrice, P-A-T-R-I-C-E, and her last name is Meinert, M-E-I-N-E-R-T.

Q Does your daughter have any guardian other than yourself?

A No.

Q Briefly, as you understand it, what events caused your daughter to be brought to Marlboro for the first time?

A The first time she was in detention and she was acting up, okay? And they-- she was taking pieces of paint and cutting her hand with it and she wound up at Marlboro.

Q What is detention?

A. Youth Detention Facility. I don't know what she had done that time to get her there, but she had wound up in the Detention Center.

Q Have you spoken with the Marlboro doctors and staff about your daughter's case and problems?

A Off and on, yeah.

Q Has any Marlboro staff member told you what her diagnosis was?

A Never.

Q Have you ever looked at her Marlboro records?

A No. The only way that I know somewhat of her what her diagnosis is, is when they submit my husband's insurance forms it's filled out on there. His -- the way his insurance pays, it's got to be filled out on his form.

Q The hospital fills out the form?

A Yes, and then they have got to mail it back to him because -- although he works in Jersey, the mother company is in California, so he's got to submit the insurance form to work here and then they mail it to California. So the hospital mails the filled out back to my house and then my husband brings it into work.

Q What diagnosis appears on the form?

A I've seen maladjustment to adolescence; I've seen schizophrenic, I think, on one form. That was about the two that I remember.

Q Now, has your daughter been hospitalized in a psychiatric facility before her first admission to

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Marlboro?

A. Yes, she had.

Q. Where and when was that?

A. Okay. Once in Bergen Pines. I'd say about -- that was two and a half years ago, and once at Carrier Clinic for an evaluation.

Q. How old is your daughter now?

A. She'll be 18 September 26th.

Q. What is your daughter doing right now?

A. Working.

Q. Does she have any plans for the future?

A. Yeah, she's been accepted and registered for Brookdale Community College and she starts in September.

Q. Have you ever spoken to Marlboro doctors or staff about drugs given to your daughter?

A. Yes, I have.

Q. Would you please direct yourself to the first conversation you can remember and --

A. Okay. The first time I had spoken to anybody was a Mrs. Safco who is a -- something to do with social services there and I and my daughter's Division of Youth and Family Services worker, his name is Sue Musa, had gone to speak to Mrs. Safco. My concern was that when she was in Carrier she -- that they medicated the kids an awful lot, not only my daughter, a lot of kids there

and the kids would walk around like zombies and Terri would have reactions to the drugs such as if she went out in the sun, she -- she's fair anyway, okay, but if she went out and she was taking certain medications, she would sunburn very, very easily. Her head would start itching. So I expressed that concern to Mrs. Safco saying that, you know, although she was there from detention, I didn't want her being put on a lot of drugs and stuff like that and she reassured me that they don't do that at Marlboro.

Q Was this early in the first Marlboro admission or some other time?

A Yes. Yes. Okay. And we proceeded the first time to get her out by transferring her to a private hospital and the second time we were not able to because she was Court Ordered in there and that's when the problem started.

Q Let's try and keep chronological so that we can follow it.

A Okay.

Q Mrs. Safco told you that your concerns were groundless?

A Exactly.

Q Was your daughter medicated after that at Marlboro?

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A. I got a call from her that night, okay, saying that they were about to give her an injection and I said, "How come? What, are you acting up or something?"

She said, "No. They're going to give me an injection."

Okay? So I was very upset about it and I told her to hang up, that I would call someone back there, staff there. I called the hospital back and I got in touch with a nurse on the floor. I said, "Look, I'm very concerned. From what my daughter told me, you're giving her a shot of something. She's not acting up. Why are you giving her a shot?"

And I was told, "Don't worry. It's nothing, you know, very dangerous. It's like a tranquilizer. Nothing's going to happen to her."

MR. WALLACH: Your Honor, I'd like to make an objection to that testimony for two reasons.

First of all, it's hearsay because she's talking about what some staff member said.

Second of all, since I realize this is a proceeding without a jury, it's not very helpful to anybody if we don't know the names of the people to whom she spoke. It's impossible to rebut it or ascertain whether there's truth

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to the statements.

THE COURT: Do you know the name of the person to whom you spoke?

THE WITNESS: She had an accent, okay? I know her if I see her, okay, and I can get her -- I can get her name.

THE COURT: I'm going to allow the testimony because I think all we have to do is look at the medical record on this individual and we'll find some notation on it as to what the injection was, if there were an injection, and I'm going to allow it.

Please proceed.

THE WITNESS: Okay.

THE COURT: You'll try and get the name and supply it to Mr. Wallach?

MR. GELMAN: We will as soon as we can complete the Xerox and introduce the records.

THE WITNESS: Okay. I was told not to worry, it was no -- okay. I was very upset about it, so I tried to call my daughter's case worker. I did not get my daughter's case work. There's an emergency worker on who called the hospital --

BY MR. GELMAN:

Q You're referring to DYF now?

A Yes, Division of Youth and Family Services. He called them. He called them and I told him under no circumstances whatsoever were they to give the shot. I was not giving them permission. Bill Sayers, who was the emergency case worker at that time, called the hospital and told them, you know, "The parent doesn't want you to give her the shot. She's very upset about it."

When initially I had called, the woman said someone from the hospital would call me back and speak to me about the shot. Bill called the hospital and then Bill got in touch with Sue Musa, who is Terri's case worker. Sue called the hospital. By that time they had already given her the shot. Sue expressed to them also how upset I was and at that point Sue Musa told me that nobody from the hospital would be calling me back and she was scheduled to get another shot the next morning and that's the way it stood.

Q Why didn't you talk to her doctor at any point in time? You spoke to a case worker and social service worker?

A Couldn't get him. You know, I left messages, "Please have him call." You could not get the man.

Q Do you remember his name?

A Yeah, Dr. Smith.

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Q Why exactly were you so concerned at that time? Was it something Terri said or something you knew?

A Well, I'm very allergic, okay? That's part of my problem. They hadn't even taken a case history on the kid to find out if she had any allergies or anything else like that at all. Now, I already knew she was showing symptoms of some allergic reaction in she was getting the itching from medication that she had gotten before and one would assume that either they would have gotten contact to me to find out, if they couldn't get it from her, if she didn't know she was allergic or anything before they had given medication to find a case history from me, which they had not done.

Q Had you told the hospital before this point in time about your concerns over your daughter's earlier reactions to the drugs?

A No. I just expressed to them that I was very concerned about them medicating her and when Mrs. Safco said, "Don't worry," at that point I had trusted her.

Q Do you recall the approximate date?

A No, I don't.

Q The year?

A It was last year.

THE COURT: Do you know what the medication was?

THE WITNESS: Yes, I found out it was Prolixin.

BY MR. GELMAN:

Q Did you talk to anybody at the hospital the day after the injection?

A Yeah. Well, I had gone to see her in that stretch. When I had gone to see her the next day, she was already having, like, her whole neck was distorted. You know, she couldn't move it. She was having problems with her jaw like locking and stuff like this and in the interim, I had called the Mental Health Advocacy to find out, you know, what could be done. She had told me that she had wet the bed at night and didn't know why and she was very concerned about that. The only releif -- and I asked then, "Can't you give her something?"

"No, it's not from the medication that she's getting these side effects," is what I was told.

Q Who said that?

A The staff there.

Q A nurse? Attendant? Doctor?

A Yeah, anybody that I would ask. You know, I would ask, "Well, can't something be done?"

Finally, I think it was the next day, I brought my brother-in-law up with me and we saw the director of

the hospital because we were so concerned and I had gone to the library and photostated a copy of the specifications of the drugs, along with the side effects, and when he tried to tell me, "Well, what your daughter is showing is not from the drugs," I showed him in black and white that it was and also that -- there was something in black and white that said what they could give her to stop these side effects of the drug.

Q Do you know the name of the gentleman you were speaking to, the director?

A Yes, Mr. Ray Ethlinger.

THE COURT: What's the name again?

THE WITNESS: Ray or Roy Ethlinger.

THE COURT: Ethlinger?

THE WITNESS: Yes.

BY MR. GELMAN:

Q Do you know whether Mr. Ethlinger's a doctor?

A No, he's not.

Q Did Mr. Ethlinger say anything to you to indicate that he had spoken to the Mental Health Advocate's office?

A No, he did not. He called another doctor in who was -- to checked to make sure if those were the side effects of the drug and he was supposed to look into the -- to the case, which he did, and this

doctor met us back at the children's ward and then they gave her a shot which stopped the side effects -- you know, stopped all the effects to, you know, the locking of the jaw, which was really terrified of. You know, she couldn't get her --like, the teeth were completely out of alignment and her neck -- within, like, three to four minutes, all that stopped.

Q What was the name of the doctor, if you recall, who went with you and Mr. Ethlinger to the children's unit?

A I'm not sure.

Q Do you know whether the drug which was given was the drug you had suggested be given?

A Yeah. It starts with a C and if you mentioned it, I would probably know.

Q Was it Cogentin?

A Yes, that's what it was.

Q Did this second doctor, the doctor who went with you to the children's unit, talk to the treating doctor while you were there?

A Treating doctor was not there at the time and the reason we had gone to the director is we had spoken to the treating doctor, Dr. Smith, and he was no help whatsoever. When I tried to pin him down as to why they gave her the shot without my permission and to see

the records to see if she was acting up at the time, nothing. I mean, he -- I couldn't get anything out of him and my brother-in-law, he was usually a very, very mild person, got very upset with the -- with the doctor and that's why we walked over the director because we were getting absolutely nowhere with this Dr. Smith.

Q You and your brother-in-law saw Dr. Smith at the hospital?

A Yes. Yes, before we went to the director.

Q Did you have an appointment with him?

A Yeah, we made arrangements to see him.

Q After the shot of Cogentin, was your daughter given any additional doses during that admission --

A No.

Q -- of a tranquilizer?

A No -- well, she had gotten other tranquilizers, but no more Prolixin that time.

Q Do you recall the names of the other drugs she got?

A At one time I think she was on, oh, Lithium, Thorazine, and I also think she was on Benedryl for side effects.

Q Approximately how long did that first admission last?

A I don't know. It would be in the record. You

Know, it sort of meshes together.

Q I understand. Did you have any other contact with Marlboro Hospital staff about drugs during that admission?

A No.

Q Was your daughter, after discharge, taking drugs?

A No.

Q Do you know whether drugs were prescribed after her discharge?

A I don't think after the first time, no.

Q Your daughter was admitted to Marlboro a second time?

A Yes.

Q Do you recall when that was approximately?

A No, I don't know what the interim was.

Q Did she go to the children's unit again?

A Yes.

Q Did you talk with any Marlboro doctor or staff about drugs during that second admission?

A Yeah, because she got Prolixin again the second time, you know, after the whole rigamarole of the Advocacy being there and them well aware of her reaction to the Prolixin and my feelings about it. The second time when she was admitted, she was given Prolixin again.

THE COURT: By injection?

THE WITNESS: By injection, yes.

BY MR. GELMAN:

Q How did you find out that she'd received the Prolixin injection then?

A Well, Terri would call me and, you know, tell me what was going on.

Q Why didn't she want it, from what she told you?

A Because she didn't like the side effects, what it was doing to her.

Q What did you do after your daughter had called you?

A I went over to the hospital again and I made them give her something to stop it.

Q You told them what drug to give again?

A Yeah.

Q And they gave it?

A Yeah.

Q Did you see anything that you thought was a side effect while you were there?

A Before she got the injection to relieve it?

Q Yes.

A Yeah. It was the same sort of thing, the -- it's almost as if she was, like, spastic. She couldn't control, you know, the movements of her body and she,

you know -- with her neck and the mouth and stuff like this.

Q For the record, what was it about the neck which seemed unusual?

A She couldn't adjust it right. It just --

THE COURT: Would it flop over? Could she hold it?

THE WITNESS: Like this she was almost.

THE COURT: The witness designates like the head flopping over to the right.

THE WITNESS: Yeah.

BY MR. GELMAN:

Q The neck was stiff?

A Yes.

Q With the head in that position?

A Yeah.

Q Now, you mentioned something about the jaw or the face?

A Yeah. It was almost as if the lower jaw had, you know, moved out and it was completely out of alignment with the top part.

Q Now, when you got to the hospital on this occasion and you saw the side effects, did you point it out to somebody on the staff?

A Yeah. I said, you know, "Hey, you better give

her something and you better do it right now."
Q Who did you say that to?
A One of the aids there and, you know, I said to them, "Look, I don't want to go through what I went last time. She's obviously having a side effect." Okay? So they had to-call up someone to get permission because it wasn't written on her chart and they got permission to give it and they gave it.
Q They gave the medication to relieve the side effects?
A Exactly.
Q What happened?
A Again, she was okay, when she got the medication.
Q Did you have any other contacts with the hospital during that admission over her medication?
A No. The one thing that I was real -- you know, other stuff didn't bother me because it seemed that she was relatively able to handle that, you know, although being spaced out, you know, and if you'd go speak to her, sometimes she would nod out on you and stuff like that. That didn't bother me as much as, you know, this physical-type thing.
Q When you say "other stuff," you mean other drugs?
A Yeah that she was getting. Okay? Like if we'd

take her home on the weekend or for a day, she couldn't go use the pool in our backyard because if she was out in the sun, her head would itch. She would burn very, very quickly, that type of thing.

Q You said she was dozing off?

A Yeah, she would. You know, if you went to visit her, every so often she would doze off or forget, you know, what she was talking about.

Q You thought that was from the drugs?

A Oh, yes.

Q Why?

A Because she normally didn't do that.

Q Did she complain about the drugs, other than Prolixin, to you?

A No, not really.

Q Did the hospital have your permission to give those other drugs?

A They never asked me for permission for anything. All they wanted from me was to pay the bill.

Q You didn't fight with them over those other drugs, though? Is that what happened?

A Well, I, you know, kept saying to the doctor, "Will you please lower her dosage?"

And he'd tell me, "Well, it's got to be lowered gradually."

THE COURT: Did anyone ever call you in and sit down with you and discuss a treatment plan of any nature?

THE WITNESS: Absolutely not.

THE COURT: How long was your daughter in there the first time?

THE WITNESS: The first time that she was in, I think three or four days until we could transfer her to a private hospital.

THE COURT: The second time, how many days was she in there?

THE WITNESS: About two weeks, I'd say.

THE COURT: All this time there was never a conference held with you by any staff?

THE WITNESS: The only conferences that were held were held on my insistence of getting information and wanting to talk to someone to find out what was being done.

THE COURT: On what level was that? The treating physician?

THE WITNESS: The treating physician, if I saw Dr. Smith, maybe two times in person and it was never "This is what we're going to do and this is the therapy that she's going to get," or anything else like that.

THE COURT: Never laid it out for you?

THE WITNESS: Never.

THE COURT: You may continue.

BY MR. GELMAN:

Q Is Terri taking any drugs now?

A No.

MR. GELMAN: I have no further questions.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. WALLACH:

Q Do you know the date that your daughter was admitted to Marlboro for the second time?

A No. It would be in the records.

Q Does January 18th, 1979 sound like about the right date?

A Could be.

MR. WALLACH: I think that's the date the records would reflect.

Q At the time that your daughter was admitted --

THE COURT: What date was that again?

MR. WALLACH: January 18th, 1979.

This is the second admission.

THE COURT: Thank you.

BY MR. WALLACH:

Q On admission, do you remember speaking to either

Dr.Smith or Mrs. Safco?

A Yes, I may have spoken to Mrs. Safco.

Q Did you tell Mrs. Safco at that time that you did not want to discuss your daughter and that you had relinquished all right to your child to DYFS?

A I told --

Q Or words to that effect?

A After dealing with Mrs. Safco the first time, okay, and not trusting her because, from what she told me, that, "Don't worry. We don't medicate them," and I found that not to be true, I no longer trusted the woman. Okay? And I also felt that I did not want to deal with her.

Q You still haven't answered my question.

A Will you --

MR. WALLACH: Perhaps the court reporter can read back the question.

(Designated question read back.)

THE WITNESS: I told her that I did not want to discuss it with her and that one of the things that I was thinking about doing to find a placement for my daughter was relinquishing rights, but I did not say that I had.

BY MR. WALLACH:

Q How was the hospital supposed to know about this alleged allergy to Prolixin if you did not tell Mrs. Safco?

A On her first admission she never took a case history. Why did she not take a case history and find out?

Q Mrs. Berkwits, I think this will go better if I provide the questions and you respond.

THE COURT: Respond to the question.

MR. WALLACH: Will you read that question.

(Designated question read back.)

THE WITNESS: From her previous admission.

BY MR. WALLACH:

Q You did not tell anybody on that second admission, anybody on the hospital staff?

A I would assume that they had had previous records there that they would look up.

Q You're not answering my question. My question is, did you tell anybody on the hospital staff at the time --

THE COURT: She didn't do it. She based her decision not to do it on the basis of previous records, perfectly valid reasonable

assumption.

THE WITNESS: If Mrs. Safco asked me, by the way, did she have any allergies, I would have told her.

THE COURT: That's why we have records, Mr.Wallach.

Let's go along.

MR.WALLACH: Your Honor, I don't think that's necessarily the issue.

THE COURT: If there are records there,you can assume that the hospital will review the records. It's normal, reasonable, proper.

MR. WALLACH: I think your Honor is making quite a few assumptions.

THE COURT: Well, I made it. I'm the judge.

Let's go along.

MR. WALLACH: But I still have the right to pursue questions?

THE COURT: Sure. You may pursue the questions. That's why records are kept. You may pursue the question.

BY MR. WALLACH:

Q. All right. Mrs. Berkwits, I believe, if I

understood you correctly on your testimony before, you said that you weren't sure how your daughter ended up in the Detention Center?

A That time, whether it was charges, okay, that we had charged because we had problems with her running away and stuff like that and we had charges on her. What the charge was that time, I don't know.

Q Are we dealing with two different instances now? Is that what you're talking about, the two times your daughter was admitted to Marlboro or are you talking about other instances where she went into a hospital?

A I'm talking about being in detention, okay, for charges filed or whatever.

Q When she was in detention and she ended up at Marlboro, was that the first admission or second admission or both?

A The first time that she wound up was from detention.

Q Do you have any idea what the charges --

A The charges were? I don't know specifically. I'm sure you could find out.

Q Well, if you were the one who made the charges, perhaps it would be helpful if we could find out from you.

A I'm not sure if it was because she had run away

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at that time or what the specific charges were.

THE COURT: Had she run away at that time?

THE WITNESS: Or it was -- I'm not sure what the charges were at that time. You can-- you know, if I have to sign to get the records, you're more than welcome to the records.

MR. WALLACH: I'm just really trying to find out how much you knew about your daughter. I think that's some indication of the concern that you have for your daughter is how much information you have about her.

BY MR. WALLACH:

Q The second time she was at Marlboro, you said she came there by a Court admission; is that right? The second time or the first time or both?

A The second time the Detention sent over her, too.

Q Both times was it done by a Court?

A I don't know what the procedure was the first time. I think they take her to see two doctors who are not even psychiatrists which is something that I also raised a whole hoop-a-lu about and they just look at her, sign her in. As a matter of fact, one of them

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is a surgeon.

Q You're still not answering my question. I'm trying to find out, you said in your testimony that one of the times your daughter came in by some sort of Court procedure. I'm trying to ascertain which admission it was and, if you know, what the procedure was.

THE COURT: If you do, you do; if you don't, you don't.

Q If you don't know the answer, tell me. That's -- your reference was to a Court Ordered admission. That's where I picked it up.

A Through the detention they -- they got two doctors to sign her in.

THE COURT: Is that the proceeding you're talking about?

THE WITNESS: That's the proceeding I'm talking about.

MR. WALLACH: That's what you mean by Court Ordered?

THE WITNESS: Yes.

MR. WALLACH: That's what I'm trying to find out.

BY MR. WALLACH:

Q Did you ever request a copy of your daughter's

records while she was at Marlboro?

A I asked to see them and I was told I could not.

Q Did anybody give you a reason?

A No. He gave me -- as a matter of fact, my brother-in-law was there with me, so -- at that time.

Q Did you ever make a request in writing to see the records?

A No, I never made a request because then at that point we got involved with the Advocacy and I signed papers that they could get the records.

Q Did you ever write any letters to the hospital staff at Marlboro?

A Write a letter to the staff?

Q Yes, or the hospital at Marlboro?

A No.

Q What was your daughter's condition the second time she was admitted to Marlboro, as best you remember?

A I think she was acting up again in detention.

Q What do you mean by "acting up"?

A Okay. Terri very early on realized that if it's a choice of being locked up in detention, which is very much like a jail, or a more freer-type thing, which is a mental hospital where she can watch TV when she wants, she can have much more leeway, that she's

going to manipulate to get into the hospital so she would do things to make them send her there.

THE COURT: Such as?

THE WITNESS: Such as take from the paint, you know, pieces of stuff and write on her arm, okay, or refuse to take a shower or, you know, just general obnoxious behavior, absolutely refused not to do anything.

BY MR. WALLACH:

Q Going back one stage in a behavior that led her to the Detention Center, where she then manages to manipulate herself to the hospital, what kind of behavior was she exhibiting that led her to go into the Detention Center?

A Sometimes it was running away and sometimes it would be a confrontation between her and I where she would get out of control.

Q Your daughter was discharged from Marlboro the second time, you said, about two weeks later, approximately?

A Approximately. The record would -- it could have been longer.

Q What was her condition when she was discharged?

A All right.

Q You said your daughter spent sometime at

Carrier Clinic?

A Yes.

Q Could you tell us what you understand Carrier Clinic to be, what type of place it is?

A I know what it is.

Q Okay. Fine. Tell us, please.

A Okay. It's a -- in the broad sense of the term, it's a mental hospital also, except it's very much nicer than Marlboro. There's no comparison. It's like a country club.

Q It's private?

A Yes.

Q Do you know how much it costs a day to have somebody stay at Carrier?

A Yes, I know what the costs are.

Q Could you tell us, please?

A At that time I think it was about a thousand dollars a week.

Q Do you know how much you were being charged for your daughter's stay at Marlboro, approximately?

A Yeah. Now it's -- I think it's up to $76 a day.

Q Which is about $500 a week, approximately, more or less?

A Yeah, and Carrier Clinic is up to $1500.

Q Carrier Clinic is now $1500 a week?

A Right.

Q That's $75,000 a year, more or less?

Any other charges at Carrier Clinic or just the $1500 a week? Do they charge you for other things too?

A That's a flat fee.

THE COURT: Where is Carrier Clinic located?

THE WITNESS: Bell Meade, isn't it? Yeah.

Can I explain why she was at Carrier Clinic?

MR. WALLACH: Sure.

THE WITNESS: Okay. Terri was classified in our school system as emotionally disturbed and sent out of our township school to go to school. She's got an IQ of above 120 in the school that she was going to was not meeting her intellectual needs. So she was sent to a school up in Bergen County, which is called the Homestead School, and it was a residential school and the school -- residential part -- at the end of that year, the residential school closed and they were looking, Division of Youth

and Family Services, was looking for -- to see what kind of placement that they could find that would serve both her intellectual needs as well as her emotional needs and that's why she went into Carrier Clinic.

BY MR. WALLACH:

Q How long was your daughter at Carrier Clinic?

A I think about six weeks.

Q Was she on medication when she was there?

A Yeah, she was.

Q Do you know what kinds of medication?

A She was on Lithium there; she was on Thorazine.

Q Any others that you know of?

A If you mention them, I'd probably know.

Q You think she was on others, though?

A Yes.

Q Was she receiving any medication for side effects, such as the Cogentin that was discussed with Mr. Gelman?

A She did not have this -- this, you know, type of side effects that she was exhibiting at Marlboro.

Q Do you know if she was on high dosages of drugs?

A I don't know what I would what high would be.

Q Well, you used the words "high dosages" and

"low dosages" before, so I thought maybe you had some understanding of what those drugs meant. That was your characterization of high dosages and low dosages. If you don't know what that means, fine.

A If you're getting 200 milligrams at a time of Thorazine, to me that's a high dosage of Thorazine.

Q Okay. Was she on high dosages of drugs at Carrier?

A I would say -- yeah, what I would consider high.

Q Was she on 200 milligrams or more at Marlboro?

A Yeah, at various times.

Q Do you remember the highest dosages that she was on approximately at Carrier of Thorazine?

A No, I don't.

Q Was it -- it was over 200 milligrams a day?

A I don't know. I do have a copy of records, I think, at home that I could look up; however, when she was released, she was released on no medication whatsoever from Carrier.

Q She subsequently was sent to Marlboro twice?

A About six months later.

Q Let me ask you when you were at Carrier, did you have conferences with doctors?

A Yes.

Q What -- how did they handle it? Tell me what

they did?

A Okay. The psychiatrist there said first of all at Carrier, she had individual therapy, group therapy. Group therapy was once a day and I think she saw the doctor, I think, three times a week, something like that, and he also had conferences with us, you know so at least they tried to come up with some sort of treatment plan there.

THE COURT: Were you advised as to what the diagnosis was?

THE WITNESS: Yeah, maladjustment to adolescence.

THE COURT: Was there a discussion with you of what the treatment program would be within the Carrier Clinic?

THE WITNESS: Within the Carrier, yes. They explained, they used, you know, group plus individual therapy to help her work it out. The only problem it was a short, you know, it was a short time stay.

THE COURT: Did they give you an idea of what the prognosis would be? Did they tell you something about the prognosis?

THE WITNESS: No.

THE COURT: When she was discharged,

did they have a conference with you to the extent of how to handle situations with her, what to do?

THE WITNESS: Part of the problem of discharge, the reason she was discharged is, they had been in a private place. Okay. And, Medicaid was paying for that. Okay. The Medicaid ran out and all of a sudden she was okay.

THE COURT: Who said she was okay?

THE WITNESS: They discharged her.

THE COURT: Was there a conference with you before they discharged her?

THE WITNESS: The day before we were told you have got to come and get her the next day.

THE COURT: You may continue.

BY MR. WALLACH:

Q During the time your daughter was at Carrier, did any of the staff particularly the physicians, discuss with you the medications that she was on and their side effects or possible side effects?

A At one point, yes. One of the doctors did.

Q Can you as best you can, try and tell us what they said, the kinds of things they said as best you

can remember?

A At that time we were told about, I'm trying to think if Steve was with me or not or if it was Bonnie, about what the side effects could be. That was the only time anybody sat down and told me about possible side effects the drugs. I don't remember what he listed.

Q Okay. When your daughter was at Carrier, the times you saw her -- strike that.

How many times did you visit your daughter when she was at Carrier?

A I went up, I'd say, at least twice if not three times a week.

Q When you saw her, was she ever sleepy, drowsy, dopey?

A No. We use to walk around and do things over there.

Q She ever show any signs of being made tired from the medication?

A As a matter of fact, one time she did have a reaction while at Carrier. Okay. To something, I'm trying to think what it was, whether she stiffened up -- yeah. She stiffened up. I went to the nurse's desk and they gave her something immediately for it.

Q Did she stiffen up right in front of you or

was she stiff when you got there?

A I don't remember. I think -- I really don't remember.

Q Possibly she already had had that condition when you arrived and you pointed it out to the nurse and she took care of it?

A I can't say what is possible because I don't remember.

Q Is there a time limit on the amount of time somebody can stay at Carrier, as far as you know?

A As long as someone's willing to pay, I don't think so.

Q You describe an incident where you called up the hospital, Marlboro Hospital and requested that your daughter not receive a shot?

A Yes.

Q I believe if my understanding of the record is correct, that was within a day of your daughter's second admission, that it was around the time of the admission, it was either the 17th or 18th of January, 1979. I believe this incident was within a day or two of that time. Is that your recollection or not? Was it near the beginning of her second admission that you called?

A No. I had called the first time that she had

been in and they had given her that.

Q Did you call when she was admitted the second time or not?

A No, I don't think so, you know, they had given it to her and I think I went over that time and that I made them give her something to stop it.

MR. WALLACH: Your Honor, I think in light of some of the testimony, it might be useful if Mr. Gelman would produce at least for the record, the records from Carrier, if there would be no objection to that.

THE COURT: Mr. Gelman.

MR. GELMAN: I would be glad to try and obtain that. I don't have them.

MR. WALLACH: I believe Mrs. Berkwits may have a copy.

THE WITNESS: I may have a copy.

MR. GELMAN: If that is so, will you give them to me and I will give them to Mr. Wallach.

MR. WALLACH: I believe Mrs. Berkwits said she had a copy.

THE WITNESS: I may have a copy.

MR. GELMAN: Will you give them to me?

THE COURT: Do you have any objection

going, the second time I entered there, I tried to commit suicide. I -- I came from the doctor and told him I didn't feel good. I said I want to go up and do something. He told me to go up, start upstairs and I will see you the next day. I ended up in there. When I got there, I didn't want to sign myself in because I was there, you know, once. I hated the place. And, he said, all right, sign yourself in and I will take you up. I got out, four months.

Q Was this about fifteen years ago?

A Something like that.

Q Did you get any drugs at Graystone like Thorazine or Mellaril?

A The first time I went there they put me on Thorazine. But the second time they put me on Mellaril.

Q About how long, countingaall your admissions to Graystone, were you on the drugs?

A Well, on Thorazine and Mellaril, then when I refused to take Mellaril, I didn't want it. It was, I was like a zombie, I didn't care about my appearance, use to have the Graystone haircut. I didn't care what I looked like.

Q What is the Graystone haircut?

A It's cut, like here, they put like a bowl on your head. That's what we call it. I didn't care what

I looked like. I took myself off of the medicine. I was all right. Then, I -- then, I got arthritis in my hand or sometning and they put me on Valium, five -- fifteen milligrams a day. Then they transferred me to main building. So when I got there, I was on the south side for six months. It was an open ward. Then they were making the closed ward. They put me on 46. They transferred me there.

Q Were you a voluntary patient all this time?

A No, because I told you I don't remember, the last time, '64 when I went, I don't remember coming. my mind was like a blank. When the Court stepped in, I think in '75, something, my daughter came in and we had to go to the dormitory.

Q Were you a voluntary patient at anytime in '75 or later, if you know?

A After that when the Courts, when we went with my daughter and he says how come I'm here so long, then I became a voluntary because my brother and doctor admitted --

Q Were you ever an involuntary patient after you went to Court in '75 or were you voluntary throughout that time?

A Yes, I was.

THE COURT: What was it, voluntary?

WITNESS NUMBER 2: Yeah.

Q Now, you said your first admission was about 1961 and you were there 1975?

A I was.

Q Right?

A Yes.

Q About how many of those years did you get the Thorazine drug, one year, two years, ten, five?

A Well, till I went in the second time I was on Thorazine. But then they put me on Mellaril the second time. Then when I came back the third time they still kept me on Mellaril.

Q Well, let's add up all the times you were on Thorazine or Mellaril. How many years are we talking about?

A It's hard. I know I was on Mellaril I think a long time. Then Valium, maybe a year. But then when we went on 45, Dr. Leibo took me off 12:00, then 8:00 and took me off 8:00 at night.

Q When did you stop taking Mellaril?

A Just before they transferred me to main building. That must have been in '76.

Q And you say you stopped taking it?

A Yes. Went in the office. I didn't want to take it because I was always in the bed. I was a mess. I

figured it must be the tranquilizer. So I just went in the office and I said I wouldn't take it.

Q What do you mean always in bed?

A In the bed. I didn't -- I was always tired and didn't care what I looked like. When I got off the Mellaril, I straightened out. Then I got a permanent, the first permanent I got when I was in Graystone. I started to care what I looked like. I wasn't tired.

Q You think that is because you weren't taking the drugs?

A Yeah.

Q Why? Why?

A When I went off the drug, I figured it was the drug that was making me tired, like that all the time.

Q How could you tell it was the drug?

A Because when I was off of it, I was full of pep. I wasn't in the bed so much.

Q Did you have any other problems you thought were a result of the drug?

A Well, I couldn't concentrate. I couldn't do nothing. I worked but it was when the patients had to work there, you know, well really had to work. I use to work and everytime I had a break, I was on the bed.

Q Do you live in the hospital now?

A No.

Q When did you get out?

A October the 20th, last year. I was living in the traditional house. That's how they got me out.

Q Are you taking any drugs now?

A No. I'm only taking a high blood pressure pill.

Q Now, when you told the staff you wanted to stop taking Mellaril in 1976, they permitted you to do that?

A The nurse was bothering me everytime she gave me medicine she has to put on the chart, refused, refused. Then Dr. Miller came one day and she told him so he said if I'm not complaining, not to bother me. So she didn't bother me and nobody bothered me.

Q You were allowed to stay there without taking any drugs?

A Yes.

Q Did anybody then or any other time at the hospital tell you what the side effects of the drugs were?

A I know there were side effects. I know the Mellaril, I think Mrs. Ray, she said we'll give you something for side effects. I said why should I take a pill that's going to give me side effects and take another one, I ain't gonna take nothing. Why should I take two pills instead of one?

Q Did the hospital after 1976 ever make you take

a drug or were you allowed to refuse drugs all the time?

A I did refuse but when I don't know. What happened to my arms, Dr. Miller said he put me on Valium but when I went, when I got transferred to the main building, I was taking -- I was taking off of it.

Q Did you take the Valium?

A Yes. But then I was always tired.

Q On Valium?

A Yes.

Q You took it?

A I took it when I was on 47. When I went over to 46, I talked to Dr. Leibo, I says, I know I'm always tired, I don't want the medication at 12:00. He said all right, and I kept taking it for a while and then I said I don't want the 8:00 medicine. He said all right and a little while then he took me off the 8:00. Till I wasn't taking nothing.

Q Did you ever start taking one of those drugs again?

A Yeah, when I signed myself out for that week. Then I was back in a week. My daugther brought me back because I had no place to live. So I was on medicine. They ordered something.

Q What did they order?

A I don't know what it was but I, I went to bed. I didn't even go to supper. I -- my daughter called. I never woke up. In the morning they couldn't wake me up at 6:00. I didn't want to take it. I was fighting with them.

Q They, are you saying they ordered a drug for you and you were sleepy again, you didn't want to take the drug?

A Yes. One of the patients said your daughter called last night. She said we tried to wake you up. We couldn't do it. At 6:00 you have to get up. They couldn't get me up for breakfast.

Q Were you a voluntary patient or involuntary?

A Yes.

Q Voluntary?

A Yes. I said I ain't taking the drug. They said you have to and I said I am not.

Q Who said that?

A The nurse. You only stay on admission five days. Then I was transferred to Abell.

Q Another part of the hospital?

A Yes. I was transferred there.

Q Did you take any drugs there?

A Well, I was there, I think, a couple of days. No they have staff for the new patient. I went to staff.

The doctor, Dr. Shapiro (Cepero), he said I'm going to give you a tranquilizer, only five milligrams in the evening. I only sleep three, four hours a night. He said it will make you sleep. I didn't know what it was. So when I got in line, she says it's Mellaril, the liquid. I said I can't take the pill. If I take the liquid, I said, I'll be -- I wouldn't be able to move. So I refused to take it. The next day I saw him again and he --

Q The doctor?

A Yes. He said what's the matter with you, you don't want to take the Mellaril? I said I can't function on the pill, how can I take the liquid. I said no, he said I'll give you something else, five milligrams and I got in line. The nurse says ten milligrams. I said he said five. I'm not taking it. All right. Then he called me -- again I talked to him. He said I'll give you something else. I took the pill but about 8:00, about 12:00 I went in the office to Mrs. Cell. I was scratching. I had welts all over me. So I said, I took the pill. I said, look, I can't sleep, look at me. She said, I'll write it in the report. You'll see the doctor in the morning. I seen him and he says it's nothing, the pill is, you know, I said it's the pill, when I don't take tranquilizers I am all right. The

minute I take something, something happens.

Q What pill was that?

A I don't know what it was.

Q Didn't anybody tell you?

A I don't know the name of the pills because only, only Thorazine and Mellaril. I don't know those new pills.

Q Did you take that new pill?

A Yes. That's what happens. So I says, I'm not taking nothing.

Q What happened then?

A I wasn't getting nothing. Then he was transferred either to Unit B or Unit A and Dr. Talbo or whatever his name is, she came on our ward. He was still there. I had a fever of one hundred and two for four days and he comes and says he'll give me something. I'm allergic to Penicillin and he gave me Penicillin. I broke out in a rash. I was scratching. So I ran away from the place for two days. They brought me back. But I kept going in the office. I wanted some lotion or something. When the doctor comes, we'll order something. That's what they said. Never saw a doctor. Then I went to the supervisor, Mr. Bonna. I said look at me. She says all right, go to your bed and room and I'll get a doctor from Unit B. I waited

all that day, all night. The next morning I just walked off the grounds.

Q Where did you go?

A Walked around Morristown and all over.

Q HOw did you get back to the hospital?

A I took the bus back. It was -- and I stepped in the coffee shop for cigarettes and cop was there and of course the doors locked, are locked at 8:00, shouldn't be out. He says where are you from. I said from the Abell. He said where is your privilege card. I said I said I ain't got one. They never gave me one. So they took me to Abell, to the supervisor's office and we walked in and he says to her, does this thing belong to you.

Q You were this thing?

A The cop says to the supervisor, she says yeah, she belongs to me and she said, I was suppose to be on bedrest. Then she said, you know, you're on bedrest. I said yeah, that's how much youse care. I could drop dead and you wouldn't care. After that I saw a doctor and they gave me Calamine Lotion.

Q Did you get any drug like Thorazine?

A No. When they had me at staff, Talbo -- I can't say that doctor's name, he --

Q It's all right. Go ahead.

A Oh, she said, you got to take something. I figured I take something and they wouldn't bother me. But whatever I took -- I wouldn't take it. So I wasn't taking it and so one day I was sitting in the dining room. She comes by. She comes by and says --

Q Who?

A The doctor. She says are you going to get an injection today. I said no I am not. I said I never had one and I'm not going to get one. She said yeah. So I came out of the dining room and there was a room there with a table and two rockers. So I sat down and lit a cigarette and here walks in four attendants and one male attendant and he says, come, we're going to give you an injection. I said no, no you're not. Miss Lighty, she took the cigarettes so she wouldn't get burned. Miss Stokes was there. I don't know the male attendant. They brought him from Ward F. I said I'm not going to get an injection. He said to me, who do you think you're talking to. I said what do you mean, who I'm talking to. I said, who are you. I said I am not taking it. So they grabbed me under the arm here, pushed me to the nearest bedroom, threw me on the bed and gave me the injection and when you know, when they walked away, they were laughing. It was a joke to them.

Q What drug was it, do you know?

A Prolixin.

Q HOw did you feel after that?

A I was going to run away again. But, I was too sick. I thought my head was going to explode. I didn't sleep. My body was jerky. My heart was pounding. I was off the bed into the bathroom and off the bed and back to the bathroom.

Q How long did that kind of thing last?

A They said she was going to get one every week. But I didn't. So then, you know, I was suppose to move in Traditional HOuse but they couldn't open the house. They found an apartment, you know, and I was going to get out. Several times she came on the ward and she said to me, did you find a place. I said no, I didn't find a place yet. So she said, you know, you can't stay in a psychiatric hospigal if you don't take tranquilizers.

Q Who said that?

A The doctor. I said I am not taking them. When I find a place, I'll get out of this rat hole and I got out.

Q Do you know the date, even approximately when you got this Prolixin injection?

A Must have been in August. That's when I ran away.

Q Of which year?

A Last year.

Q 1978?

A I got out in October.

Q Did anyone tell you you had a right not to take the drugs?

A Well I figured the last time I got off the Mellaril, you know, nothing happened. I didn't think they would, you know, give me an injection. I kept saying no, no. I didn't think they would do it. But they got rough.

Q Did anyone who worked for the hospital ever tell you whether you could or could not turn down a drug?

A No. But, when I went off of it, so I figured I'm going to refuse. They ain't going to do nothing. The nurse, everytime I wouldn't take the pill, she says if you don't take the pill, we'll give you an injection. I said oh no you're not.

Q Are you taking any drugs now?

A Just high blood pressure. I have high blood pressure.

Q Did any doctor ever tell you what good or bad you could expect from the drugs like Thorazine and Mellaril?

A No.

Q Did any nurse or attendant or anybody else at the hospital ever tell you what you could hope to gain or lose from the drugs?

A They said if you get side effects, we'll give you, you know, something, another pill.

Q Did they tell you what the side effects were?

A No. If you get them -- I figure if I don't take any tranquilizers, I don't need the other pill for the side effects.

Q What did you think the side effects of the drugs like Thorazine, Mellaril and Prolixin are?

A Well, when I was on Thorazine, when I got, when I was discharged I was home, I was all right for a while then I was nervous. I went back to my own apartment. I just had to walk from room-to-room. Everytime I sat down on a chair and put the television on I'd jump off, shut it off and go from room-to-room. I was a wreck.

Q You think that was because of the drug?

A I was a wreck.

Q Why? Do you think it was because of the drug?

A It had to be.

Q Not just thinking of you, Witness Number 2, other patients that you saw?

A A lot of patients that have side effects from drugs.

Q What are the side effects?

A They talk to themselves. They laugh. They act funny.

Q What do you mean by funny?

A The way they talk, what they do.

MR. GELMAN: I have no further questions.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. WALLACH:

Q At this time would you believe in August was when you received the injection?

A Yes.

Q I think you said Prolixin?

A Prolixin.

Q At that time, did you threatened to kill yourself or say something to that effect?

A Yes, because I couldn't see a doctor, because I had that rash. She says she'll give me the shot because I was going into the office and bothering the nurse too much, because I wanted something, some lotion. I was bleeding from scratching.

Q And you, you were at Graystone about how many

years were you at Graystone, would you say approximately, total?

A. About seventeen.

Q. Seventeen years. That incident in August, was that the only time that somebody ever gave you medication against your will like that?

A. Yes.

Q. In the seventeen years you were there?

A. I was never in seclusio room. I never had an injection.

MR. WALLACH: That's all I have.

No further questions.

THE COURT: Any redirect?

REDIRECT EXAMINATION

BY MR. GELMAN:

Q. One question. Who said that you were going to get the drugs because you complained too much?

A. The doctor.

Q. What was the doctor's name?

A. Talbo or whatever her name is. I couldn't see her, you know, everytime I went to the office,you have you've got to have an order, you have to have an order for aspirin. When the doctor comes in, he'll order it and you'll get it. They kept going -- I went to Mrs.Bonna, supervisor. I showed her. I couldn't stand

no more. She said go in your room and I'll call up the call to see if we could get a doctor. When she went off duty at 4:00, no doctor never came. So the next day in the morning I just took off.

Q Were you complaining because you wanted to see a doctor?

A Yes. Then I took off.

MR. GELMAN: No further questions.

MR. WALLACH: No questions.

THE COURT: Thank you very much. You may step down.

Call your next witness.

MR. GELMAN: May I have a five minute recess at this point?

THE COURT: All right. We'll have a ten minute recess.

(At which time the Court stood in recess.)

THE COURT: Be seated everyone.

Mr. Gelman, you may call your next witness.

MR. GELMAN: We call Peggy Allen.

THE COURT: Peggy Allen?

MR. GELMAN: Yes.

P E G G Y A L L E N, Sworn.

THE COURT: What is your last name?

THE WITNESS: Allen.

THE COURT: A-L-L-E-N?

THE WITNESS: Yes, sir.

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MR. GELMAN:

Q Where do you live now?

A Chesilhurst. Chesilhurst, New Jersey.

Q Have you ever been at Ancora Psychiatric Hospital?

A Yes.

Q When were you first there? What year?

A 1965.

Q How old were you then?

A About ten years old. Ten.

Q Have you been in and out of Ancora ever since 1965?

A Yes, up to this -- this year, '79.

Q Were you ever released between 1965 and 1979?

A Yes.

Q How many times?

A I don't know. I couldn't keep count.

Q You were released a lot of times and readmitted

a lot of times?

A. Yes.

Q. When was the longest period of time you ever stayed out of the hospital before you were readmitted?

A. About a year.

Q. How long have you been out of the hospital now?

A. Going on two months now.

Q. Were you ever treated with drugs like Thorazine or Mellaril or Prolixin at Ancora?

A. Yes.

Q. Beginning when?

A. I think I had it when I was younger, then when I was, what? 17, 16 I was in Willow Hall and I had tooked Thorazine and when I got discharged about several months later, I got hepatitis from it. They said it was a bad dose of medicine I got from the hospital.

Q. Were you on medication at Ancora most of the time? All the time?

A. Most of the time I was, yes.

Q. You said you were discharged the most recent time when?

A. I was discharged May 17, 1979.

Q. And when did that admission begin?

A. October 1977.

Q So the last hospitalization was from October '77 to May '79?

A Right.

Q Were you treated with drugs during this admission?

A Mostly thorazine.

Q When did they start treating you with drugs?

A Oh, when I first got admitted, they had me on I'm pretty sure it was Mellaril. Then it made me sick. Then I had to go onto the Thorazine, they put me on.

Q What do you mean it made you sick?

A It made my blood pressure very low.

Q Why do you think that was the drug?

A That's what the doctor said. I don't know. That's what he presumed. That's what he thinks.

Q Which doctor was it?

A I think it was Woodward.

Q Were you a voluntary patient during your last admission or involuntary?

A I was and then I was Court committed at the end, toward the end.

Q You were voluntary in October '77?

A Right.

Q And when were you committed?

A I think it's '78. '78.

Q Did anyone ever tell you why you were getting the drugs, like Thorazine, what they were for?

A No. They just said I had to take the medicine 'cause I needed it. So I took it, you know.

Q Well, when you say all you were told is you had to take the medicine because you needed it, is that what Dr. Woodward told you?

A All he told me, right.

Q Did the nurses ever talk to you about the drug?

A Not until the last -- about January they started having class and talking about side effects. That's the first I ever heard of it since I been coming there. They were talking about side effects toward January. They had a class.

Q January?

A '79.

Q And these classes were open to patients who wanted to attend?

A Right.

Q What did they say in the classes?

A They were just telling you well, you know, what it might do to you and what it might not and what to expect and if you have any questions, ask the doctor or nurse, you know.

Q Do you remember what they told you the side effects were?

A Like they said with Thorazine, if you got out in the sun, you could burn very bad.

Q Anything else?

A That's all I remember. They said it makes you burn pretty bad and I know because I have.

Q Did you complain about the drugs or did you take them?

A I took them until January when I became pregnant and then I refused them.

Q Now, why did you take them before January? Did you think they were helping you?

A No, because they made -- I was doing nothing but constantly sleeping because I was on such a high dose. I was on so much I couldn't do nothing but -- all I did was sleep. I couldn't do nothing but sleep.

Q Why didn't you complain about that?

A I was but the doctor I needed it and had to take it.

Q Was the dose lowered when you complained you were sleeping?

A No. I was on it -- I was on twelve hundred a day of Thorazine a day.

Q How sleepy were you?

A I did nothing but constantly sleep. The only time I woke up was for eating, unless I took a shower or something. That's the only time I found myself waking up.

THE COURT: You say you were on twelve thousand?

THE WITNESS: Twelve hundred a day.

THE COURT: Milligrams of Thorazine a day?

THE WITNESS: A day, right.

BY MR. GELMAN:

Q But when it was time to take your pill, you took it willingly?

A Yes, until January.

Q Now, before January, if you thought the drug was making you sleepy, why did you take it willingly?

A Because I just -- I couldn't do nothing for myself. I couldn't -- I couldn't even sit up to eat, couldn't even hold the fork in my hand or spoon or whatever I ate with because I was so tired. I couldn't even see the plate.

Q Did you ever tell a nurse or doctor that you would like not to take the drug or to take a different drug?

A Yes. They said I needed it but they never told

me what for. They said, "You have to take it." They said, "If you don't, you'll get it one way or another," so I took it.

Q What did you understand them to mean you would get it one way or another?

A Either by pill or needle, so I had no choice but to take it.

Q Did you ever hear a nurse or doctor say that to any other patients?

A Well, I have. In other words, if you don't take it, you know, they're going to give it to you by needle or mouth, so they have to take their medicine, they said. If you don't take it, they said, "You get it one way or another." They said it to a lot of other patients.

Q Did the doctors say that or the nurses or both?

A Well, often the doctors say it or a nurse. If the doctor prescribed it and the patient didn't want it, the nurses say, "You have to take it. The doctor ordered it," and if you didn't take it, you got it by needle.

Q Are you taking any drug now?

A No, nothing.

Q What happened in January, '79 to make you

complain more?

A Because I became pregnant.

Q Well, what did that have to do with it?

A I did not want to hurt my baby.

Q You thought the drugs would hurt your baby?

A That's right.

Q Why?

A Because they are tranquilizers and the only thing you're suppose to be on when you're pregnant is multi vitamins. That's the only thing.

Q Did the doctors or the nurses tell you that?

A No. They wanted me to take medication but I refused it and I complained to the patient advocate. and I told them I would not take the medication and I haven't took it.

Q You started complaining and you were allowed not to take the drug?

A Right, because they say I have to take it. That's all they said, "You have to take it."

And I said, "I will not," and they were trying to force it and I went to the Public Advocate and I said, "I will not take this medicine and hurt my baby." That's what I told them.

Q Did the doctors talk with you about the effects of drugs on the baby?

A No, nothing. They said it won't hurt him. I said, "I know better than that." I said, "I have read books and seen stories. I know better than that about tranquilizers and stuff."

Q A doctor told you that the drugs would not hurt the baby?

A Would not hurt the baby.

Q Who said that to you?

A Dr. Woodward.

Q Any other doctor?

A No.

Q What ward were you usually on during this last admission?

A Well, I was on F-1. Then they transferred me to Med-Surg.

Q How did you and the staff get along on Ward F-1?

A Not too good. There was a lot of fights down there and stuff with us. I got hurt a couple times by employees.

Q How did you get hurt?

A Well, the first time I got burned in the shower and the second time I got a black eye.

Q How did you get burned in the shower?

A She put me in this chair and I don't know what

I did, something, and she turned the shower on me.

Q Who did that?

A One of the nurses that worked there.

Q What about the black eye?

A It was an attendant that did it that worked there.

Q When did that happen?

A Sometime in January -- January or February she gave me the black eye.

Q '79 or '78?

A '79.

Q Did you like the wards then?

A No, because we didn't get along. They didn't let me do nothing for myself. They wouldn't let me work around the ward to help out and I just didn't like it and the last time I got hurt, somebody from the outside came in and took pictures because I said I wasn't going to take it any more.

Q Do you know who came in and took the pictures?

A I guess it was a State Trooper.

Q Peggy, would your fights with the staff have relationship to the drugs you got or the amount of drugs? Could you see any connection?

A Well, if I didn't take it, they'd hold me down and give me a needle or something and I'd fight them

and they'd say that I hurt them or they hurt me and that's when we'd fight because if I didn't take my medicine, they'd hold me down and give it to me and that's when we'd fight a lot.

Q When did you say you were a voluntary patient in this last admission?

A I came in October 1977. I was voluntary up until, I think, '78.

Q When in '78?

A October.

Q Well, did it make any difference if you were voluntary? Were you allowed not to take the drug if you were a voluntary patient?

A Well, I don't know. They said I have to take it because they said I needed it. I had no choice but if I didn't take it, I would have wind up getting hurt or something. So I had no choice but to take the medicine.

Q It didn't matter, as you understood it, whether you were voluntary or not?

A Right.

Q Now, you said you went at some point to the Medical Surgical Ward?

A Right.

Q When was that?

A. March -- March 22nd.

Q. Of what year?

A. '79.

Q. And you were transferred there from Ward P-1?

A. Right, from P-1.

Q. Let's go back a little bit. When did you learn that you were pregnant?

A. In January.

Q. Of '79?

A. Right.

Q. And how did you find out?

A. I asked the doctor for a test and the first one came back negative and the second one came back positive. He didn't believe it so he took a third one and it came back. Then he took me off my medicine because I said I wouldnot take it.

Q. Did you stay off the medicine from that point until March when you went to the Medical Ward?

A. Well, they had me on some but I was upset a lot because I was afraid -- you know, they said they didn't want me to have the baby and I was pretty upset and everything. So I was on it for a while. Then he took me off. Then March I did something -- I can't remember -- took an overdose or something. I don't know what I done, and they took me to Med-Surg

and I was there from March until April to May and P-1 didn't want me and P-2 did not want me on their ward. They refused to take me back downstairs.

Q Did you get drugs on the medical ward?

A No, nothing but vitamins.

Q Did they try to give you drugs on the medical ward?

A No. They said I did not need them.

Q Who said?

A The doctor there, the medical --

Q What was his name?

A Li Free -- what is his name?

Q Dr. Li Free?

A Yeah, Dr. Li Free, right.

Q Did Dr. Li Free talk with you about these effects of drugs on the baby?

A Yes. He said it could harm him. I said, "I realize that."

He said, "I don't want you on nothing but vitamins," and he started me on vitamins the very next day and I've been on them ever since.

Q Peggy, do you have any opinion about why Dr. Li Free didn't try to give you the drugs when they did try to give them to you on the other ward?

A Because I was up there and he says, "If you

like to help around, feeding the patients and doing what you like to do, make the beds," he said, "If you don't feel like doing them, you don't have to."

I practically went outside with somebody everyday and I was just content and the next thing I knew was a month or a month and a half later I was out of there. I was supposed to see a doctor, some kind of doctor, and they got me out of there within a week's time. Before I even knew it, I was discharged. I didn't even know where I was going.

Q You were discharged when a doctor was coming to see you?

A Right.

Q Who was sending the doctor to see you, do you know?

A Public Advocate.

Q Do you know why the doctor was going to see you?

A Because of court and stuff and I was out of there in a week's time.

Q This Court?

A Right.

Q When did you learn that you were going to be discharged?

A A week before the doctor came. It just came up

all of a sudden on me. I was out and gone. That's all I know.

Q You haven't had any drugs since?

A No, nothing.

Q You said you were allowed to go outside and to help out and make beds on the medical ward?

A Right.

Q Were you allowed to do that on the other wards?

A No. They always kept me on a locked ward. I couldn't go out or nothing.

Q When you say you couldn't go out, how much time would pass without you going outside?

A Sometimes a week, two weeks, and then maybe a week -- two weeks later I'd go out and maybe another two,three weeks before I went out again.

Q What do you mean by help out? What would you do?

A I, like, used to make beds, help feed the older patients, comb their hair, but they wouldn't let me do that on F-1 and then I went to H-3 and I was no problems, nothing happened. I was just really calm as I could be and they couldn't see nothing wrong with me and the doctor said he didn't want me on no tranquilizer or nothing. He says, "She don't need them," and I told them I didn't need them, either. You know,

the baby and stuff and I was all right and they were happy to have me there and they said if I was gone they'd miss me. If I needed anything, to write back.

Q H-3 is the medical ward?

A Medical ward, right.

Q How would you spend your time on F-1 and F-2? What would you do?

A I'd just sit around all day, maybe watch TV and just sit. That's all I would do is just sit from sun up to sundown.

Q What about occupational therapy? Did you have that?

A Sometimes they would come to work. Sometimes they'd show up and sometimes they wouldn't.

Q Do you think that having something to do made it easier for you to be calm?

A Oh, yeah, made me feel comfortable, made me feel relaxed and comfortable and I was satisfied and no problems at all.

Q Peggy, did anyone ever tell you what your diagnosis was?

A No, I never -- no way, no.

Q Did anybody ever tell you what they hoped would happen to you?

A They didn't say -- they didn't really say too

much. They just kept me there and I stayed there because I had no place to go until this year and all of a sudden I was taken out the door as fast as a bullet.

THE COURT: Where are you staying now?

THE WITNESS: Chesilhurst, New Jersey.

THE COURT: With whom?

THE WITNESS: Mrs. Miller. It's a guest home. She just opened up in December.

THE COURT: In other words, Ancora transferred you to that home?

THE WITNESS: No. I was in Lindenwold at the time and I moved in the last few weeks from Lindenwold to Chesilhurst.

THE COURT: A private family?

THE WITNESS: No, this is a regular guest home. She just opened up in December. She just passed her license and everything.

THE COURT: I see.

THE WITNESS: Right.

BY MR. GELMAN:

Q Peggy, did you ever have a treatment plan?

A. Well, they were talking about it off and on then it would die off and they'd talk about it off and on and then it would die.

Q What do you mean they'd talk about it? What would they say?

A They said they were hoping to get me out and it would be two, three weeks before I heard something. Until -- and May popped. All of a sudden I was out of the door before I knew it. They found a place -- I don't know -- so fast, I was practically -- my head was spinning.

Q NOw, you said you were involved in fights on the other wards?

A Right.

Q How would the fights start? What would happen?

A Well, they wouldn't like what I was doing or something, you know, say something. I'd wind up getting hurt or they would get hurt and I'd be in trouble and restraints or something, you know, and we were always -- somebody didn't like the way I talked and if I didn't do what they say, I'd wind up getting hit or something.

Q You would be hit if you didn't do what you were told?

A Right.

Q Would you hit back?

A Yes, to defend myself.

Q Did the patients fight with one another?

A. Well,the way I looked at it, employees encouraged the fights.

Q. What do you mean they encouraged the fights?

A. They'd know if you were good with them they'd hire you to beat up another patient.

Q. What do you mean?

A. They'd give you something to beat up another one and they'd defend you.

Q. Did they give you anything?

A. No. I'd get so upset they'd be hitting me and I'd hit back and the last time I got hit, I said I didn't want to take it any more fromthe employees.

Q. It was the favored patients?

A. Right. If you'd do something for them, they'd fight.

Q. Who did you ever see do something to a patient to start a fight?

A. Well, attendants and people.

Q. Do you know their names?

A. Not that I remember, but I know the last person hit me, the only reason I was afraid to say anything because her husband was a security police and that's why I wouldn't say anything in the beginning. Then somebody walked and seen my eye. Then I told them the truth, I was afraid to say

something because her husband was a security cop there.

Q One of the staff members hit you and it was her husband who was a security officer?

A Right. I was afraid if I said something he might get me.

Q And why did you finally say something?

A Because somebody -- I don't know who it was. I think it was either Judy or somebody seen my eye and asked me and I told them the truth.

Q Did anyone else ask you about your eye?

A No. At first she was kind of like threatening me. I told her I fell out of bed, you know, but they figure if you fell out of bed, you'd have a bump on your head, too, but the only thing it was, was my eye, black.

Q Who did you tell you'd fallen out of bed?

A A couple employees. I don't knowwho they were. I told them I fell out of bed.

Q Why didn't you tell them the truth?

A Because I was debating. I didn't know what they would do, too. I didn't know if they really liked her or not, you know.

Q If you were in one of these fights, Peggy, would you get more medication or not?

A Yes.

Q Did you ever think the fights were your fault?
A Sometimes they were and sometimes they weren't mine. I admit sometimes I'd fight and maybe sometimes I wouldn't -- and I'd be in a fight, the next thing I know.
Q Well, if it wasn't your fault --
A Right.
Q -- and you thought it wasn't your fault, would you still get your medication?
A Yes, because they'd feel I was upset. They'd say, "You need something."
And I would say, "No." And they would give it to me anyway.
Q Give me an example of how you could be in a fight when it wasn't your fault.
A Well, if I said -- you know, somebody said something to me and I said -- they'd come up and hit me beside my head and I hit them back. They'd figure maybe because I had a temper or something, I started it and they gave me the medicine. They figured I needed it and gave it to me.
Q They gave you an extra dose?
A Right.
Q Would you see a doctor first?
A They'd have to call the doctor and they'd get

it -- extra medicine. I wouldn't see the doctor.

Q They'd get permission over the phone?

A Over the phone.

Q Did you ever have a chance to tell your side of the story, why you thought it wasn't your fault?

A Once in a while but not too much.

Q When you had that chance, who would you talk to?

A Well, I started going to the Public Advocate because I didn't know who else to go to.

Q Who's the Public Advocate?

A Rose Swelto.

Q What would Mrs. Swelto do for you?

A She'd talk to me, check it out, she'd get one side of the story and I'd tell mine and most of the time it was the same thing I'd say, everybody else would agree with it that happened.

Q Peggy, you were on drugs for about a year and a half and now you've been off drugs for a couple months?

A Right.

Q Do you feel any differences?

A No. I feel good.

Q Aside from the drowsiness, did you notice any other difference?

A No. I feel comfortable. I don't feel as nervous. I feel myself sleeping better at night and eating.

Q Have you been in any trouble since you were discharged?

A No, none.

Q Was there any trouble at all while you were on the medical ward not getting drugs?

A No. I was just like I am now. All right. No problems or nothing.

Q Can you tell when you're all right and when you're not all right?

A I can feel myself. I start crying or something if I get upset but I haven't even felt sad. If I feel myself getting upset, I go to the lady or somebody I know and talk to them.

Q Peggy, did my office do anything for you?

A Yes, you helped me a lot.

Q How?

A When you came and talked to me and stuff, I told you what and you helped me out and checked it and sometimes -- most of the times the story was right and about the medicine and when I first found out I became pregnant, I called Judy and told her and she wrote a letter to the head doctor and told him my

situation, that I didn't want themedicine. They didn't want to test me at first and when the letter went through, everything went all right.

Q What do you mean they didn't want to test you?

A To see if I was pregnant. They didn't want to do it at first.

Q And Judy Cracker wrote a letter?

A Right.

Q How do you know she wrote the letter?

A I was at the hospital at the time. She had a copy and I had a copy and the people upstairs had a copy.

Q And after the letter, they agreed to test you for pregnancy?

A Right.

Q Did the letter make any difference to whether or not you got drugs?

A Yes, because I told them I didn't want to hurt the baby and eventually theymust have listened to her because I said I'm not taking them and they finally died off. At the end I didn't take they any more.

Q Now, did you talk to the medical director, Dr.Pepernick or any other doctor about these drugs when you say you didn't want them?

A Well, Dr. Li Pree didn't want me taking any kind of medicine, not even an aspirin unless I had to take an aspirin because he said it would hurt the baby.

Q Do you know who Dr. Pepernick is?

A Isn't that him now?

Q The gentleman at the table?

A I'm not sure.

Q Did you talk to Dr. Pepernick about the drugs in the last admission?

A I don't know. I can't really remember, to tell you the truth. I don't know.

Q Do you believe what the hospital doctors tell you, Peggy?

A Not all of them, no. No.

MR. GELMAN: No further questions.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. WALLACH:

Q Did you ever request any of the doctors or the ward staff to receive medication?

A Yes, once in a while but not too much, no.

Q Why did you do that?

A Because I felt I might have needed something because I felt really upset, you know, and I figured maybe it would help me but sometimes it made me very

sleepy.

Q Did it help you sometimes?

A Sometimes it did and other times I wouldn't take it because it was too much.

Q Were there times when you were at Ancora when you didn't want to take the medication and the doctors or the staff let you not take the medication?

A Well, at times they said I had to take it. No matter what, they made me take it.

Q Were there other times when they then let you not take it?

A At the end I didn't have to take any, no.

Q You said your last admission to Ancora was in October of 1977?

A Correct.

Q What were the circumstances that caused you to get readmitted at that time, as best you remember them?

A I think I -- I don't know. I was -- I just signed myself in because I was having family problems at home. That's what I recall. I'm not too sure.

Q And when you were discharged in May of 1978, how were you feeling then?

A Pretty good. I had a good attitude towards life and they figured I'm ready, so I went out and I

have had no problems since.

Q This -- where was the place that you went to live when you left Ancora?

A When I first left Ancora, I went to Lindenwold and I lived there a month and then I moved up to Chesilhurst.

Q How did you arrange to live at this place in Lindenwold?

A They -- they put me there in Ancora, the people. BTA, Bureau of Transition Service, they put me there.

Q How did you get to this place you're staying at now?

A I called my case worker, whatever she is, and asked her could I move.

Q They arranged for this new placement?

A Right.

Q And you're happy with the new placement?

A It's very nice, yes.

Q When you were at Ancora, did you ever hit other patients?

A Yes.

Q Staff?

A Yes, off and on and vice versa.

Q Did you ever attempt suicide?

A Yes.

Q More than once?

A I did it because I feel -- I really didn't do it because I wanted to die because I feel I wasn't getting enough attention and the only way they listen, if I done something to myself, then they may pay attention to me.

MR. WALLACH: I have no further questions. Thank you.

THE COURT: Any redirect?

MR. GELMAN: No.

THE COURT: Thank you very much. You may step down.

(Witness excused.)

THE COURT: We'll stand in recess now until 1:30 and we'll have lunch.

(Luncheon recess.)

(The following takes place in open court.)

THE COURT: Gentlemen, I want to place on the record some requests and direction which I have reached as a result of the informal discussions with counsel in my chambers. I want to put on record the plaintiffs are expected to finish their case

July 20 and defense by August the 3rd. By July 20 I also expect plaintiffs to submit a detailed request for relief. This need not be an amendment to the pleading but must contain specific proposals for the type relief sought. The defendants shall submit a written response to this document within ten days after it is submitted. We will also conduct informal conferences about the proposal.

In addition, I request both parties to submit briefs indicating the effect of the Parham case on this litigation by July 20. Any reply briefs in response will be due the following Friday, July 27th. Any motions to certify sub-classes of minors shall be heard around July 20.

Finally, assuming we can meet this schedule, plaintiffs and defendants shall submit findings of fact and conclusions of law by August the 7th. All transcripts shall be delivered within two days of the final hearing date, which is expected to be August 3rd, 1979. I have discussed this schedule with respect to the transcripts with my court reporter and he informs me that that

schedule is feasible and will be complied with as far as he is concerned.

I know, gentlemen, it's placing a lot or pressure on you, a lot of work. But, I am sure you can understand our reasons for it. We have to bring this thing to a head. We have to get it determined and let see if we can all work toward that end.

MR. GELMAN: I believe that Mr. Wallach and he can correct me if I am wrong, we agreed that the plaintiffs might have July 23rd for one of their experts.

MR. WALLACH: Yes.

THE COURT: All right. Call your next witness, Mr. Gelman.

MR. GELMAN: Eugenio Burgos.

E U G E N I O B U R G O S, Sworn.

DIRECT EXAMINATION

BY MR. GELMAN:

Q Where do you live now?

A I live in, 90 NOrth 20th Street between Westfield and Federal.

Q Are you a patient in the Tris program now?

A Yes, I am.

Q What is the Tris program?

A Well, Tris program is like residence. It's like between from the hospital, they take people out of the hospital and put into these houses and have to go to some kind of therapy in the after, during the day.

Q The hospital you're talking about is Ancora Psychiatric Hospital?

A Yes.

Q Were you a patient there?

A Yes.

Q When were you first a patient there?

A When I -- I think it was 1970.

Q Have you been a patient on and off since 1970?

A Yes.

Q When did the most recent admission to Ancora begin, do you know?

A Most recent was like in December -- September, last year.

Q Are you taking any drugs now?

A I taking Novine and Cogentin.

Q Novine and Cogentin?

A Yes.

Q Do you know the dose of Novine you're taking?

A Yes.

Q What is it?

A. It's one tablet Novine in morning and one tablet and Novine and Cogentin during the night.

Q. Are you comfortable on those drugs?

A. No, no.

Q. What problems do you have?

A. Well my vision is just not clear and I got dry, hot, I have to drink a lot of water. I'm dry all the time. I have to drink a lot of water.

Q. Were you on any other drugs while you were a patient at Ancora this last time?

A. Yes, I was. I was in on medicine but don't remember the name. I don't remember the name of the medicine that they made me take in the hospital.

Q. Before you were admitted --

A. Yes.

Q. While you were at the hospital the most recent admission --

A. Yes.

Q. What drug were you on?

A. Don't you have it in the paper?

Q. If you remember.

A. I don't remember.

Q. Were you given drugs by pills or by injection?

A. By injection at first.

Q. Do you know whether the drug was Novine or a

different drug?

A It was a different drug.

Q Was it Prolixin?

A I think so. I think so.

Q How often did you get an injection?

A Every week or every two weeks, I think.

Q How did you feel while you were receiving the Prolixin?

A Well when I was going to first be admitted to the hospital, they gave me an injection. I didn't know what the medicine -- I feel like dropping on the floor because I didn't have no strength, myself and my body was like, my heart was goind one way and my mind was going -- my feelings were in disorder.

Q Do you feel that way on NOvine?

A On Novine I feel just dry mouth and clear vision and like threwing up.

Q Were you a voluntary patient or involuntary patient on your last admission?

A I think I was voluntary but then they had to admit me, made me sign in so I should be admitted. I think I was to court and everything because I didn't want to stay.

Q You said you were made to sign something when you were admitted?

A Yeah.

Q Do you know what it was you signed?

A I think it was admission papers.

Q How were you made to sign it?

A Well, they tell me, we went over a card, will you please sign these papers and that's all.

Q Said anything about court? I didn't understand you.

A They said something about court and tell me I should sign those papers. I didn't know aboutit.

Q Did you understand what those papers ay?

A I don't remember.

Q Did you talk to anybody about your feelings on that drug?

A It seems to me like these, these men in the hospital, there's no such adequate treatment for human beings like, if you have ever a reaction, they tell you you're just playing around, you have nothing. Sometimes they don't help you. They just -- the doctor, you know, if you got a problem and you want to talk to a doctor, you're afraid of him, to give you more medicine or not help you at all with your problems.

Q Did any of that happen to you?

A I -- yes. I feel like an animal and doctor was an enemy to me. Everybody around there, like, I don't

feel like they're giving me any help. I feel they were enemies and they were out to harm me.

Q Is the Tris program out to harm you?

A No.

Q You trust them?

A Yes.

Q Who did you talk to about your medication?

A Well, I talked to Jim, H-I-M. And I talked to the doctors and I talked to a nurse and they were telling me I was, that we was, that I have nothing, don't worry about it, the doctor will come in in a few days.

Q What doctor did you talk to? Do you remember his name?

A They change. I don't remember. They change. I have three doctors since I have been there.

Q You have three doctors?

A Yes.

Q What problems did you tell the doctor you had with the drug?

A Well, I, I, I think I tell the doctor that it would give me a bad reaction.

Q Well, did you mention any reactions in particular?

A Yes when I did but I don't remember what I

mentioned.

Q Do you remember what reactions you had?

A WEll, it was like I wasn't on the floor and I was. Like I said before, I was, my heart was going like I feel like my heart was going all around my chest and my mouth was going and my mind was going somewhere and my neck was going somewhere else and I feel like I was feeling very bad sometimes in that period of time. Before that when I went to the hospital, they gave me Thorazine and I couldn't, coulda't be in the sun. I couldn't be burned and they gave me another medicine and I think I got burned, you know. I got like I didn't have control over my hands or my feet. They would just bend down.

Q What happened to your feet, do you know?

A They would go like this.

Q Bend?

A Bend.

Q Would they do anything else?

A Well, I tired to get up and just fall down.

Q You weren't able to stand?

A Not for a long time. I would bend like this.

Q Why do you think it was the drug that did it to you?

A Because when I went to the hospital, I didn't

have that until they gave me the medicine.

Q Does the Novine and the Cogentin do anything like that to you?

A Some.

Q Which?

A I think Cogentin.

Q What do you do?

A Well, it's kind of, Cogentin makes me dry.

Q Makes you dry?

A Makes me very dry. Makes me like my tongue very dry and inside very dry.

Q What about your hands and feet, does it effect that?

A No.

Q Do you feel better on the Novine and Cogentin or did you feel better on the Prolixin?

A I feel better on the Novine and Cogentin.

Q A little better or a lot better?

A A little better.

Q You said you were, you said patients were afraid of the psychiatrists?

A I was.

Q Why?

A Because they're saying something I would, I would go off to talk to a psychiatrist and I would

have to be a dayroom and the psychiatrist would be in the office and it was hard to me to communicate with the psychiatrist. When I went to the psychiatrist, I had to have limits and I couldn't say pronouns like they would ask me and I would say visions or I would hear voices and I, they would tell me it was my nerves or my family or it was a sign to have me here rather than in society or on the street. They just gave me an amount of drugs that I couldn't handle. I was afraid.

Q You said psychiatrists wouldn't talk to you about your problems?

A No, would not. He just answered that question, and that's all.

Q Those are the limits that you mentioned?

A Yes.

Q Was it easy to see a psychiatrist to talk to him or her?

A No. It's very hard.

Q What do you have to do?

A Well, the psychiatrists usually are out of the building. He is not in the closed ward or in the open ward. He is in different places and it's very hard to get a psychiatrist.

Q Does the psychiatrist ever come on the ward and

let any patient who has a problem come up to him or her?

A Well -- whoever have a problem, usually he have to deal with it during the day and the psychiatrist would be summoned and he would have a list of the ones he would like to see and if he wants, didn't want to see him, he wouldn't. If he was able to see him, he would.

Q How do you get your name on that list?

A A knock on the window. I say, I bother her but you know, it was sometimes I would try to get his attention while he was working but you know, sometimes he would see me and sometimes he wouldn't see me.

Q You knocked on the window of the nurse's station?

A Yes, while he was there.

Q Why couldn't you go in?

A It was a patient in there.

THE COURT: Do the psychiatrists have an office right in the ward?

THE WITNESS: Yes.

THE COURT: His own office?

THE WITNESS: No, not in the office. He have a nurse's station.

THE COURT: At the nurse's station?

THE WITNESS: Yes.

THE COURT: But does he have a private office of his own away from the nurse's station but within that ward, a section of the ward, a section of that ward cut off and that's the psychiatrist's office?

THE WITNESS: Yes.

THE COURT: It is?

THE WITNESS: Yes.

THE COURT: You may proceed.

BY MR. GELMAN:

Q What ward were you on?

A I was in D ward, Holly Hall. Then I was transferred to Cedar Hall.

Q Cedar Hall. Now, on Holly Hall D, how many doors would you have to go through to get to the psychiatrist's office?

A Well, it's hard to -- one door, one door and it's hard to see the psychiatrist in the ward, you know. I have to be like a patient.

Q Was the door you had to go through to see the psychiatrist locked or not locked?

A It was locked.

Q How much time does the psychiatrist spend on the ward or in the nurse's station or anywhere else?

A He would spend 9 to 12 and that's all.

In the morning?

A In the morning.

Q Would he be talking mostly to thepatients or writing in the charts or what?

A Mostly writing the charts. Like you know, say something to them and they would come over and what kind of psychiatrist -- all the time I've been in the hospital, I been a few times in hospital and there was, he would come on with a different, a different -- they don't come up with it --

Q A diagnosis?

A Diagnosis.

Q Did anyone ever talk to you about what the drugs could do to you?

A They tell me about it and I cannot refuse to take it everytime they like, he said you don't take the pill I have to give you an injection which they did because I wasn't taking the pill.

Q Who said that?

A The nurse.

Q And you were given an injection?

A Yes.

Q How did you see the doctor before you got the injection?

A Yes.
Q How many times did you see one, two?
A I just seen, in all the time I was there I seen three doctors.
Q You had three different treating doctors?
A No, one at a time.
Q One at a time?
A One at a time.
Q Did you ever see any doctor other than your treating doctor about drugs?
A No. They each had to give you a paper and they said that you have to take the medicine. You don't have to take the medicine if you don't want to but . like they tell me like we have to control you somehow in here. All the patients over there, they have to be doped up.
Q Doped up?
A Yes. Most of them and they really can't handle the problem they should.
Q What were you told the drugs could do to help you?
A Nothing.
Q What were you told the drugs could do to hurt you?
A A lot because they would, they would, they would

make me feel like uncomfortable first and I wouldn't know if I was crazy or not or what was the dope making me that way. My mind was going one way. I couldn't think right. I wasn't able to walk right. If I was standing here, I have to get up. I couldn't stand still.

Q You couldn't sit still, either?

A Couldn't sit still.

Q That's what you felt on the drug, correct?

A Yes.

Q What did the hospital tell you you would feel on the drug?

A I don't know because they never talked about it.

Q You say you did tell your doctors that you didn't want the drugs?

A Yes.

Q How many times would you talk about that?

A I talked about it all the time.

Q Just the doctors?

A The nurse and the doctors and I had to get a Public Advocate to do something about it because they tell me that I had to be there, I had to be given medicine to be there, otherwise you know, I couldn't be in the hospital.

Q They told you if you didn't take medicine you

would have to leave the hospital?

A. What was the reason to be in the hospital? You know, tell me what you're doing here. This is a place to keep you down or otherwise --

Q. What do you mean they said you were at the hospital and you had to take medication?

A. You have to take dope in the hospital. Otherwise why should you be in the hospital.

Q. That's your opinion or that's what you were told?

A. That's what I was told.

Q. When was the drug changed to Novine?

A. It was changed about, I think, it was about a month ago, a month and a half ago.

Q. Why was it changed?

A. Because I talked to Public Advocate and they take actions.

Q. Do you know what they did?

A. Yes. She sent a letter to a doctor and doctor changed it.

Q. What, what Public Advocate did you speak to?

A. I think I was to her, to her and you.

Q. I still don't understand why you would be afraid to tell your psychiatrist about things?

A. Well, I was afraid because one time I was

admitted and I tell them I was afraid and they said well, let's get him frightened more. That's what I hear from one psychiatrist, not from all of them but one of them. It seems to me like, you know, you don't get a help like you get more harm than you get help. When you go out of there you give, they give you more medicine so you can't stay out here. While in there they give you high dosage.

Q High dosage --

THE COURT: Did you have any psychotherapy sessions with the psychiatrists?

THE WITNESS: Well, no.

THE COURT: Just medication?

THE WITNESS: Yes, just medication.

THE COURT: What did you do by way of keeping yourself busy?

THE WITNESS: I had to walk all over the ward.

THE COURT: Pardon me?

THE WITNESS: I had to walk all over the ward.

THE COURT: Any games to play?

THE WITNESS: They have games like nobody there, everybody is walking or watching the TV.

THE COURT: Any athletics of any nature?

THE WITNESS: Sometimes, once a week they take you to a gym. But, not everybody goes to the gym.

THE COURT: Is there any daily calisthenics or something like that in the ward area?

THE WITNESS: No. Just have a room like this. Everybody sits down. That's all.

THE COURT: You watch television?

THE WITNESS: Yes.

THE COURT: You may proceed.

BY MR. GELMAN:

Q Do you remember having a hearing in State Court?

A Yes.

Q Do you remember talking about your medication there?

A I don't remember that good but I, I think I did talk about it.

Q Why are you taking the Moving pills?

A Well I don't take it, it -- I take Moving it do me good. I think it's there because it's a rule of the hospital. It's the steps they take in the

hospital. It's -- if I would have a choice, I wouldn't take it. I wouldn't have it, if I had a choice.

Q Do you know why you're taking the Cogentin or why they are giving it to you?

A Because of the side effects of the Navine.

Q What did the hospital hope to do for you, do you know?

A I'm out of the hospital and I'm at Tris residence. I think the hospital having nothing else to do with me out there, have, you know, no power over me, you know.

Q When were you allowed to go to the Tris residence?

A All allowed about a week ago.

Q A week ago. That was after your drug was changed from Prolixin?

A Well, Prolixin is been changed about a month ago. But they said you'll be better with this dope. So they tell me I should get out of the hospital.

Q Did anyone say to you we think you're doing better on this drug?

A The doctor. The doctor ordered it.

Q Is it Dr. Raveles?

A Raveles, I think. It's a Chinese doctor, I think so. Raveles.

Q Did anyone ever tell you at the hospital that they thought you were doing well on the Prolixin?

A No.

Q How long did you get that Prolixin?

A I don't know. I forget. At times like my mind went blank in there. It seems to me like all this time I've been there I like I stay overnight. I have been there --

THE COURT: How old are you?

THE WITNESS: How old am I?

THE COURT: Yes?

THE WITNESS: Twenty-nine.

BY MR. GELMAN:

Q You can't remember very well what happened to you when you were receiving Prolixin?

A I was feeling bad all the time, feeling bad and droway, tense, can't see well, can't see very well.

Q Why do you think all of those feelings were due to the Prolixin?

A Excuse me?

Q Why do you think all those feelings were due to the Prolixin, the drowsiness, tenseness?

A Because I never had -- I wasn't nervous when I come to the hospital. I just -- I first went to the hospital they told me I was, I was reading the

Bible a lot and I was talking like you know, some kind of Messiah or something like that. They took me over there. I maybe use to believe I was an Apostle. I wasn't nervous and I was feeling good and my mind was completely, you know, it wasn't ill. Right now I feel like I am broken inside and my mind is ill. I don't feel so good. I feel like in the hospital, they did me damage. Didn't do me any good.

Q Was there help that you think you could have gotten?

A Well, if they want to help they can give you help because they have the study and have the time and they have facilities for it. But over there they treat you like a dog.

Q If they offered you help would you have accepted it?

A I would gladly will but it was like nobody was willing to give me any help.

MR. GELMAN: No further questions.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. WALLACH:

Q Do you remember about when your last admission was to Ancora, approximately how long ago it was?

A It was in, I think, September, end of September.

Q Of this last year?

A Last year, yes.

Q And if I understood you correctly, you said you signed a voluntary paper to admit yourself to the hospital?

A I think so, but I think I signed another one to get out, too, and that's why they took me to court.

Q Second paper you signed, which I think is asking for your release on 72-hours notice, did you sign that a number of different times?

A Since I been in the hospital, I think so because I always been in the hospital for like seven days and they would admit me.

Q But would you request to be released?

A Always. I always would want to be released.

Q Then did you withdraw those requests a day or two later?

A Well, they always get me to withdraw where I should have been all that time in there.

Q But you did withdraw then yourself?

A No.

Q Before your most recent admission, as I understand it, when you were discharged from the hospital before this most recent admission --

A Excuse me?

Q You were in the hospital before this last time?

A Huh?

Q You've been in the hospital more than just this previous time that you were there?

A Sure.

Q Not this last time but the time before that when you were discharged, where did you go?

A I went to Puerto Rico.

Q How long did you go to Puerto Rico for?

A For a month.

Q Then what happened?

A I came back here and my sister put me back in the hospital.

Q Do you know why she put you back in the hospital?

A I don't know. I was doing good.

Q When you left the hospital when you went to Puerto Rico, were you taking medication at that time?

A Yes. Yes, I was taking -- I was in the Cherry Hill out-clinic, I think, and they were giving me Prolixin and I was having this reaction. That's when I left to Puerto Rico because I wanted to stay away from the medicine.

Q So then you didn't take the medicine when you

were in Puerto Rico?

A I didn't take the medicine in Puerto Rico.

Q When you came back to the hospital, did they put you back on medication?

A Yes.

Q Did the medication help you at all mentally?

A No.

Q Not at all?

A It destroyed my brain, I think.

Q Do you sometimes take the drugs willingly?

A I never -- you know, like, since I been in the hospital, it seems to me like no -- no kind of a medicine will help me, so it seems like everytime I have a medicine I have a reaction and I complain about it but...

Q You're in the Tris program now?

A Yes.

Q You said you started in that about a week ago?

A Yes.

Q Did the hospital place you in that program? How did you get in the program?

A Well, I think my social worker told me about it because my sister would not take me. She would not send me her place so I needed someplace to -- to live outside and the psychiatrist wanted to give me

dishcharge so Tris came around. They talked to me and they tell me I would like to go there and I said yes.

Q Do you feel that you're in better condition now than you were when you came into the hospital the last time?

A No. No, I think I'm in better condition before.

Q Before you went into the hospital?

A Yes, when I was in Puerto Rico.

MR. WALLACH: I don't have any more questions.

THE COURT: Redirect?

MR. GELMAN: Yes.

REDIRECT EXAMINATION

BY MR. GELMAN:

Q You told Mr. Wallach that you signed papers to get out of the hospital?

A Yes.

Q And you didn't get out?

A No, I didn't get out.

Q Would anyone talk to you about the paper?

A Well, the psychiatrist would talk to me, would tell me, like, they have to give me some more treatment and to sign another that would, you know, would drop -- would drop my -- my -- my request in

signing myself out.

Q And did you sign those other notes?

A Yes. I have to because he was, like, pressing me like, you know, like you have to sign this because, you know -- I don't know how to do it.

THE COURT: Who was this?

THE WITNESS: The doctor.

THE COURT: Which? Do you know his name?

THE WITNESS: They all do that.

THE COURT: They all do that?

THE WITNESS: Yeah.

BY MR. GELMAN:

Q You were afraid not to sign?

A Yeah.

Q Why?

A Because I wasn't sure of my feelings and couldn't trust him of telling me what --what's the matter, you know, and he tell me -- he didn't even tell me why I want to get out. He just telling me you sign yourself in here. He said, I feel you should stay a little bit longer. Would you sign this note because we got to go to court and things like that. Will you sign this note to withdraw this withdrawal notice.

Q Are you saying if you didn't withdraw the notice you would go to court?

A Yeah.

Q Would that be a good thing or bad thing to go to court?

A I don't know. I don't know. I don't know.

Q You were afraid to go to court?

A I was afraid of everything in there.

MR. GELMAN: No other questions.

THE COURT: Are you afraid here today?

THE WITNESS: No.

MR. WALLACH: No questions.

THE COURT: Thank you very much. You may step down.

(Witness excused.)

THE COURT: Call your next witness.

MR. GELMAN: John Rennie.

THE COURT: You've been previously sworn and your oath will continue.

THE WITNESS: Right.

J O H N R E N N I E, previously sworn.

DIRECT EXAMINATION

BY MR. GELMAN:

Q Are you taking any drugs now?

A Yes, I am.

Q What?

A Phenothiazine, six hundred milligrams, four times a day.

Q Is somebody checking your blood level of Lithium?

A Yes, Dr. Diesen, U of P Hospital.

THE COURT: 60 milligrams?

THE WITNESS: 600.

THE COURT: 600 milligrams four times a day?

THE WITNESS: Yes.

BY MR. GELMAN:

Q Has that dose be adjusted upward or downard in the last week or two?

A Upward.

Q What was it before it was adjusted?

A Three times a day, same amount.

Q When was the dosage set at three a day?

A Last week.

Q What had it been before it was at three times a day?

A Four times a day.

Q It was four then three then back up to four?

A Yes.

Q Who reduced it to three times a day?

A Dr. Kashel, the director of Unit 3.

Q Did Dr. Kashel tell you why he reduced the dosage?

A He said I was doing very good.

Q And you could get on with less?

A Yes.

Q If my memory serves me right, when you last testified, your Ancora doctor was Dr. --

A Balita.

Q Balita. And then the record shows you had Dr. Bugeaen for a doctor. What other doctors have you had since Dr. Bugeaen and Dr. Balita?

A I had Dr. Schmidthoffer and I believe that's the only thing.

Q Dr. Gray?

A Yes, Dr. Gray. I forgot him. And when I had Dr. Gray, in essence, Dr. Schmidthoffer was doing all the work on me; Gray was just signing the papers.

Q Dr. Nasanenpo?

A Yes, I have her in the last few months since Dr. Balita left my case.

Q Now, you have Dr. Kashel, is that right?

A I'm not sure. I think Dr. Kashel is on vacatio

Q Do you see Dr. Pepernick once a week?

A Every week, yes.

Q How long does that interview last?

A Five, ten minutes, fifteen, maybe half an hour.

Q When Dr. Balita was your doctor, did he ever talk to you about this lawsuit?

A Yes, he did.

Q What did he say?

A Back in November last year, after we had the second hearing in December he told me I had complete loss and that Judge Brotman reversed his decision and told me now he would begin my treatment his way and I didn't know what was right at the time. I hadn't talked to you at that time.

Q Did you talk to me later?

A Yes, but in my own recollection from what I read in the opinion, I couldn't see where it had occurred.

Q Did Dr. Balita talk to you about having the Public Advocate as a lawyer?

A Yes.

Q What did he say about that?

A Well, he don't -- or for that matter, the time a reporter from the newspaper came down, he was kind of perturbed about that, too. He didn't want me dealing with anybody outside the hospital system.

Q Did he say these things to you only once?

A He said them once, he said them a million times. He was a man I despised and hated.

Q How did he feel about you?

A Huh?

Q How did he feel about you?

A Well, when he was ahead or he thought he was ahead, he could get along with me, but when he got mad at me he was very vicious.

Q What's your life now, John? Where do you spend your days?

A I live at home by myself for the most part, seven days a week now.

Q Do you ever spend anytime at the hospital?

A I usually go back to the hospital and spend just a part of one day there checking with Dr. Pepernick and getting my medication for the next week and so forth.

Q Now, what's this arrangement with Dr. Diesen? He's not at Ancora, is he?

A No,he's at the University of Pennsylvania.

Q What's the arrangement with him?

A All he's doing right now is just responsible for taking my blood down level and giving a report back to the hospital. The hospital is responsible for

medication and my therapy.

Q Do you what your serum level is now?

A It was, I think, about 1.12. Then it was down to -- Dr. Diesen said .58 and Judy told me last time it was .77.

Q Do you have any side effects from the Lithium?

A Yes, I do.

Q What are they?

A Well, I have tremors in my hand and I'm trying, like, thumb through a book or a magazine, I can't turn the pages. I can't sometimes hold a magazine or book to read without the book shaking. I have a lot of other after visions in my eyes at night where in the dark I see flashes going through my head. I don't know what caused that.

Q You think that's a Lithium side effect?

A Well, I'm almost positive because I never experienced anything resembling that there until my levels increased to four times a day.

Q Any other side effects?

A Yes, my speech is impaired. I have a hard time talking, making myself clear.

Q You think that's from the Lithium?

A It's from the Lithium, yes.

Q Any other problems?

A I have -- sometimes if I reach down for something on the floor and try to get up real quick, I get real short of breath at times. I think that's from the Lithium also.

Q Have you talked these problems over with Dr. Diesen?

A Certain ones I have; certain ones I haven't.

Q Do you feel you have any lingering effects from the Phenothiazine drugs, Thorazine and Prolixin?

A Yes, because I seem to a lot of times almost bite my tongue in half for no conscious reason. I just do all of a sudden. I just seem to just -- my tongue gets bit and my tongue is all chewed up at times.

Q What about your jaw? Does that move?

A I don't know if it moves much but the fact that I have to grind my teeth, I bite my tongue a lot. That there frightens me.

Q Now, going back in time, was there a time when your jaw moved more than it does now?

A Yes. I mean a time when people were constantly asking me for chewing gum or something like that because they thought I was chewing, you know, and it was just the unconscious movement of my jaws.

Q Did patients talk to you about that at the

hospital?

A Not only patients, but outsiders outside of the hospital. In fact, sometimes, especially small children, two and three and four-year olds would ask me for gum, so I knew they were seeing something that was obviously in a small kid.

Q People thought you were chewing gum?

A Right.

Q When was this?

A It's been off and on for, I guess, almost -- I can't remember the time. It's a long time.

Q Do you have any opinion about what caused that?

A Well, it's hard to kind of put the blame on one particular factor, but just the -- the way the patients are treated with medication in general is what it caused it all.

Q You think that the Phenothiazine made --

A Well, I would say Phenothiazines and other drugs, too, other therapies all interact to it, but primarily the Phenothiazine.

Q Did you ever talk to Dr. Pepernick about your jaw movement?

A We're like old friends by now, so I'm sure I must have at one time or another.

Q Do you recall any particular time when you did?

A No, I don't.

Q Did he ever talk to you about them?

A I'm sure he has. My memory is pretty bad and I can't remember everything, but right now the arrangement I have with Dr. Pepernick is pretty smooth and good. I enjoy going to his office. I mean, if I had that, say, six years ago, there probably wouldn't have been all this trouble. He's a very sensitive man to me at times. I like him.

Q How long has this arrangement with you spending most of your time outside the hospital been going on?

A Well, it started last year. It stopped for a month and then resumed in January.

Q Do you recall what drugs you were getting during that time?

A In January?

Q Yes.

A Boy, I must have got a lot of stuff. I couldn't and I mentioned I've gotten drugs that aren't even on the records.

Q When was that?

A I would say I've gotten things that weren't shown on the record because I never experienced what I did in my life. I know it must have been something

that I was given that started it all.

Q You're talking about the time in NOvember or December when you were restrained?

A Yes.

Q And when there was a court hearing without you being here?

A Right.

Q Did you talk over that occasion with Dr. Pepernick?

A I talked over with a lot of people. I even tried to talk it with Dr. Balita because he was my treating doctor at the time, and with him I didn't have much success.

Q Do you have hope now, John, for the future?

A Plenty of hope, yes.

Q Why?

A Why?

Q Yes. What gives you hope?

A Well, I think primarily the opinion that the Judge rendered in November and its reception by both the professional and non-professional staff.

Q How do you get along with Dr. Diesen?

A Excellent. I got -- I didn't like him at first. The first time I saw him last year before the opinion but this period I've been going to him

after the opinion, we get along very good. He's a wonderful person.

Q John, were you at Ancora Hospital the day that Dr. Crane visited the hospital?

A Yes, I was.

Q Dr. Crane saw you; is that right?

A Just very briefly. I had expected a larger audience but there wasn't enough time.

Q Did you overhear any conversation that day about a stick?

A Oh, did I? I happened to be in the supervisor's office of Unit 3 to get my medication and to --

MR. WALLACH: Your Honor?

THE COURT: Yes?

MR. WALLACH: I know a lot of hearsay has come into this case, but I'm just not sure at this point it doesn't have any relevance.

THE COURT: What is the relevancy?

MR. GELMAN: Of the stick? If we go back, it's not close, I can see that, but if we go --

THE COURT: We went through all that. I know that exists.

MR. GELMAN: Mr. Rennie heard a conversation, I represent, about the hospital's response to the discovery of a stick in the same place on that day and that's what he would testify to.

THE COURT: I'll let him testify.

THE WITNESS: Well, I didn't know that the advocates were on Holly D. I thought it was late in the day; they returned to Trenton because I was getting ready to leave myself and the supervisor for Unit 3 was in the office all upset because a stick had been found on the D Ward, which is the closed ward for Unit 3, and at that time she mentioned that the stick was -- she was talking to the timekeeper-- the stick was in fact found by Sheldon Gelman, the Public Advocate from Trenton, and she said at that time trying -- she said the stick wasn't not a reportable item and she wouldn't make no report of it and it had been found by the Public Advocate, and so she was having the operator get Dr. Kashel on the phone, who was the acting director for that day, to find out how she would go about reporting the stick so that they're all covered, and I think, if I

might say so, she is a supervisor that I've seen in the past that has tended to cover up for shortcomings by the abused patients. She seemed to cover the report so the abuse would not show up and she's very easily, I would say, intimidated by the male staff to condone their actions.

THE COURT: Anything further, Mr. Gelman?

MR. GELMAN: No.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. WALLACH:

Q Mr. Rennie, I understand that you're taking Lithium now; is that correct, everyday?

A Yes, but with reservation.

Q What reservations are those?

A The fact that in my own mind I'm not convinced of the beneficial effects of the drug, but in compliance with Judge Bratman's opinion in November, I assume that I can conform to the system he specified for me, plus I feel that my attorneys, who act in my best interests, don't advise me badly, and so because they advised me to continue the regimented system of the drug, I take it, but I still like -- in some way,

like to see to find out if I could or couldn't do without the drug. I'm willing to go off the drug and see if what I encountered in November can, in essence, reoccur.

Q Now, since January of this year, have you taken your Lithium everyday as you were supposed to or have you missed times that you were supposed to take it?

A There have been times, Mr. Wallach, when I like have been at home in a hurry to leave the house, have left my pills behind, but those are maybe, say, one or two times over the past seven months, but most times I'd make a very conscientious effort to take the medication, even as far as doubling up if I unintentionally missed a dose during the day. I'm getting the required amount.

Q Do you have any explanation for why your level dropped in the last couple of weeks?

A That to me is unexplainable, except from the standpoint of view that normally at Dr. Dinen's, to get the blood down level, he takes it sometimes between, like, the afternoon to theevening and so it's kind of hard for you to -- to get there at a set time each day and so to keep the dose -- I mean, the level readable, he wants to skip, like, the dose at noontime

so not to cause the level to get unduly high. The first time I took it, it was at .58 was the first time I had ever taken the Lithium level in the evening instead of in the early part of the day, so you figure I had just, like, the one dose in the morning and then the dose the previous day.

Q As you've been prepared for discharge at Ancora in the last six months at various times since last fall, have you been offered opportunities to participate in treatment programs or to move, for example, onto a transitional unit?

A Well, I have been in the past, not so much this year but last year, offered to go to transitional unit, yes.

Q What was your reaction to those offers?

A Well, the programs were demeaning to my mentality and did nothing to promote my mental growth and so I felt that it would be in my best interests that I collect my own personal mental redevelopment.

Q Has the hospital and hospital staff attempted to make arrangements for you to see a psychiatrist or a psychologist at one of the community mental health centers in New Jersey?

A Well, they have tried repeatedly from last year to this to make arrangements for me to go to the --

not a psychiatrist but a psychologist at the Gloucester County Mental Health Center in Woodbury and there's a bad taste both for that clinic in my mouth and also a bad taste in their mouth for me, so that would not be a situation that would do any of us any good.

Q Why is there a bad taste in the mouths of both sides?

A Well, from my point of view, the fact that they've repeatedly insisted from the very beginning on giving me a regimented system of Prolixin and not really knowing the best course for me and I feel that's just a way of saying to come to the Center and you have to take a drug. I didn't like that because they just were trying to give me a drug that they can administer once a week or once every two weeks, knowing I'd be medicated for the entire one or two-week period.

Q Turning to Dr. Dixon, you see him once a week?

A Not normally, no. I started out seeing the doctor on once a week basis. Sometimes when I get in for a second visit or a phone call and then after a while he increased my visits to two weeks to three and now they're at four-week intervals.

Q Once every four weeks?

A Once a month.

Q How much time do you spend with him?

A With Dr. Disen?

Q Yes.

A Well, it all depends upon his schedule and his office load and the patient load at the time. I mean,if there's not very many patients in the office, he can spare a few more moments but, if there's a big backlog of patients or phone calls, then he has to shorten my visit.

Q Well, let's take the last time you saw Dr. Disen. When was that?

A What date?

Q Approximately.

A I guess about two weeks ago.

Q How long did you spend with him?

A Oh, I guess about ten minutes.

Q In your meetings with Dr.Disen, do you discuss your problems with him?

A I discuss a lot with him, yes, and then he also has contacted people on my behalf and made numerous contacts with my attorneys in Trenton so he knows quite a bit about me and then he has other patients who are friends of mine that we share thoughts between each other.

Q You said that you had discussed some of the side effects of the Lithium with Dr. Disen. Is that true?

A I tried to, yes.

Q What is Dr. Disen's reaction?

A What are Dr. Disen's reactions?

Q Yes. What did he do when you discussed the side effects with him? Did he take you off the Lithium?

A No.

Q What did he do? Did he reduce the dosage?

A No.

Q What did he do?

A Well, he was not in the position to adjust or experiment on the dosage because he was not my treating doctor. That was up to the discretion of the hospital.

Q So he didn't do anything?

A No.

Q Okay. You said you see Dr. Pepernick every week?

A Yes.

Q What happens when you go to see Dr. Pepernick ordinarily? I mean, what do you do?

A It's a very pleasant conversation and I

would'a't say it's a typical psychiatrist to patient relationship. It's more or less like a friend to friend.

Q Is that the reason why you liked it?

A. Friend to friend? Yes, I do.

Q You wouldn't like it as much if it was psychiatrist-patient?

A. No.

Q Up until fairly recently, were you having sessions with a psychologist at Ancora?

A. Well, the record may reflect that but, in my opinion, no.

Q Perhaps you better explain that comment?

A. Well, the hospital records would show I had time scheduled for psychotherapy with the psychologist but nothing was derived at from that and it was very nill. Sometimes they, I mean, that would serve, like, try and coordinate a schedule for future visits and stuff like that and I didn't, I never had time to sit down and try to pick brains with him and analyze thoughts and things.

Q Going back to the beginning when you first began seeing a psychologist, what was his name?

A. Nick Mazzagotti.

Q Was he a doctor?

A AT the time he wasn't. But he is now. He has a Ph.D. now.

Q When you first saw him, how often did you see him?

A Well, sometimes it was scheduled for twice a week. But then it was sometimes, once a week and then just quick talk in the hall sometimes.

Q Did you stop going to all the sessions?

A Yes. I was not getting much out of it. The sessions were leaving me empty because instead of talking as human beings, he talked more or less like down to me.

Q Was he also trying to be doctor-patient rather than friend to friend?

A Yes.

Q You said Dr. Masencampo, who I believe is a woman?

A Yes. Very good doctor.

Q She's been your psychiatrist most recently?

A Yes.

Q You get along well with her?

A Well, it's hard to say. I mean I didn't get her for a doctor until Judge Brotman's decision and since I got her after his decision, she's been very congenial towards my ideas and thoughts.

Q As you spend less and less time at the hospital has there been over the last six months team meetings to discuss the idea of you being discharged or deciding where you were to go or things like that?

A On a very regular basis, yes.

Q Has Mr. Gelman or Miss Cracker been at some of those meetings?

A Practially all of them. Not so much Mr. Gelman but Mrs. Cracker.

MR. WALLACH: That's all I have.

THE COURT: Any redirect?

MR. GELMAN: Nothing further.

THE COURT: Thank you very much, Mr. Rennie. You may step down, sir.

Do you want to quit for the day or do you have any witnesses?

MR. GELMAN: We have no other witnesses today.

THE COURT: Then it's a good time to quit. You've timed it exactly right, 4:00. It's careful planning.

We will resume tomorrow at 1:30. Thank you.

(At which time the matter was concluded.

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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
CIVIL ACTION NO. 77-2624

JOHN E. RENNIE,

Plaintiff,

CAROLINE MAUGER, et al,

Intervenors,

vs.

ANN KLEIN, etcetera, et al,

Defendants.

DEPOSITION OF:

DR. MAX C. PEPERNIK

DR. FREDERICK P. LO PRETE

DOROTHY LO SASSO

ROSE MARIE SUELTO

TRANSCRIPT of proceedings as taken by and before CHARLENE ANN MAGNANO, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, at Ancora Psychiatric State Hospital, Admissions Building, Room 421, Hammonton, New Jersey, on Tuesday, June 26, 1979, commencing at 10:30 A.M.

FILED

JUL 3 1979

A P P E A R A N C E S:

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DIRECT EXAMINATION BY MR. GELMAN:

Q Dr. Lo Prete, my name is Sheldon Gelman, as you know, and I'll be asking you a series of questions today in the lawsuit of Bennie versus Klein.

I would like you to answer each question as directly and completely as you can.

A If I was connected, you know.

Q Well, if you don't know an answer of your own knowledge but can only guess at it or you have heard something, we will preface your answer with that. Feel free to qualify your answers in any way you please.

A Right.

Q If you have any doubt about what the question means, please don't hesitate to ask me for clarification.

You are represented by Mr. Wallach. Is that right?

A Yes. It's new to me. Yes, I am. Sure.

MR. WALLACH: Yes.

Q If Mr. Wallach should begin speaking, please defer to him and don't resume speaking unless Mr. Wallach is finished. However, unless Mr. Wallach directs you not to answer a question, I would ask you to proceed with your answer.

All right. You're a medical doctor?

Yes, I am.

A Yes, I am.

Q What is your official title?

A Official title is Administrator of Unit 5, Chief of Medical Services.

Q Unit 5 is a ward for people with medical problems?

A Medical and surgical problems, right.

Q And you draw your patients from the psychiatric wards at the hospital?

A Right, all over the hospital. And sometimes directly from outside.

Q Dr. Lo Prete, I am going to be asking you about a particular patient, but before I do, we will have to go off the record and assign a code identification to the patient so the record will not show who she is.

A Right.

MR. GELMAN: May we go off the record?

(Whereupon, a short discussion is held off the record.)

Q Dr. Lo Prete, we have identified a certain patient as P.A. I. Was she on your ward this year?

A She was on a ward for approximately a month and I [illegible] assignment. And she was sent to us from

I think it was Unit 1. And she had a few problems down there which was pharmacologically related and that's how we got her.

MR. GELMAN: Excuse me, Dr. Lo Prete. Dr. Lo Prete named the patient. Could you just delete her name and use the designation of P.A. 1, please?

Q What problems were pharmacologically related?

A Well, apparently, down there, due to environment, per se, down in Unit 1, they -- it was alleged they had a problem of calming her down and just keeping her docile as she wouldn't become hyperexcitable, probably suicidal attempts because she was, basically, somewhat recalcitrant in her behavior.

Q Did you have these problems with her on your ward?

A No, for the simple reason that in our ward it is structured differently and when we get residents up there, they are sick and the ones who are really not that sick, immediately recognize that the ward is quiet. You've got more nurses taking care of them. And I would say [illegible] arrogantly that they're more definitely [illegible] because of a lesser amount of expertise.

We often find that patients who come on your [illegible] over precisely because the environment in

your ward is more relaxing. Is that it?

A Yes, and, you know, they're sicker in a sense and they're usually bedridden for a period of maybe 24 to 48 hours, I would say.

Q Patient P.S. 1, was she bedridden?

A No, no.

Q But she was still quieter and better behaved?

A Yes.

Q Why do you think that was?

A Well, when we evaluated her, we ascertained that she didn't need any polypharmacy. So, we discontinued all drugs. We got her on an OBS-GYN consultation and just treated her as a pregnant female who needs some reassurance or a very minimal amount of supportive care, other than good food and iron.

Q And she responded well to that?

A She responded quite well, yeah.

Q Did you see any evidence of psychosis?

A The diagnosis we had for her was borderline syndrome. This really means that you can't definitively call them schizophrenics or reactive psychotic, but have a lot of emotional flexibility. But the syndrome, itself, doesn't need any drugs, you know, to calm a patient down.

Q In your opinion, P.S. 1's condition didn't

instant drugs at all?

A Yes, that was my opinion at the time.

Q Were there other physicians at Ancora who disagreed with you?

A I don't care to answer that. I don't think that's in my purview to get speculative or to get subjective about colleagues or about any part of the health care team. My function upstairs is to take care of the patients medically and surgically with the best expertise available, and that's our philosophy.

Q Dr. Lo Prete, I understand and I commend your reluctance to talk about conversations you had with your colleagues, but you are duty-bound to answer.

A I personally never had consultation with them, but I do disagree with their management, but I never had consultations with them. Maybe some of my staff did, you see.

Q Okay. Did you find that patient P.S. I had [illegible] drug side effect when she arrived on your ward? Did she have akathisia?

A No, she didn't have that, but the side effect of [illegible] are -- you know, sometimes you don't even know you have them. But anybody who takes a drug, even with [illegible], you're going to have side effects and some effects are a positive and some are negative. It's

...seen with the resident, I'm sure the side effects were not to her best advantage. Due to the fact of her [illegible] behavior and excitement and due to the fact that she has an intrauterine pregnancy.

Q What are the clinical considerations involved when a pregnant woman in the first trimester may be given a neuroleptic drug? What should the doctor be thinking of?

A Well, in general, for anybody when you're a psychiatric resident or if you're just a normal individual in the outer environments in society, it's best not to give any female patient in the first trimester any drugs and that may mean too much aspirin or too many vitamins.

Q Was this resident concerned about the effect drugs might have on her fetus? Did she talk to you about it?

A No, she didn't. I don't think she could be capable of [illegible] understanding, per se. She was really a -- I mean, you should persuade -- let's say she was very [illegible] but that's not to say that you know that the doctor or anybody is speaking about.

Q Incidentally, where is this person now?

A Somewhere, what was it, a half-way house or a [illegible] I received a little note from her.

She's doing quite well, quite happy.

Q She was discharged directly from your care?

A Yes.

Q Without any drugs being given?

A No drugs other than prenatal care which is folliron, ascorbic acid and vitamins. Let's say teletvitamin plus iron supplements because of, you know, the pregnancy.

Q Approximately how long had she been hospitalized, if you remember?

A I couldn't tell you definitively but I can just, you know, as I heard that she was hospitalized here at Ancora?

Q Yes, yes.

A Gee, I'd say about two years here.

Q Was it also your impression that she had been given neuroleptic drugs regularly during that time?

A That would just be my impression, yes, but I don't know, you know.

Q Is it surprising to you that someone who has to be hospitalized while they received neuroleptic drugs apparently can be discharged as soon as the neuroleptic [illegible]

MR. [illegible]: May I have the privilege of answering [illegible] in psychiatry? That when you have

a psychosis in this society, there is no reason why you should have to stay in the hospital more than three to six weeks, in general. That will cover a good 90 percent of psychosis.

Q The neuroleptic drugs, those are given in the hopes of speeding discharges. Isn't that right?

A Not necessarily, no.

Q What other reason could they be given for?

A Well, first of all, to take him out of a psychotic state, whether it's an organic or a functional psychosis. Okay. Now, when they're out of a psychotic state, most patients can be discharged. Many patients have still to be discharged as neuroleptics, especially the functional psychosis which is relegated to the schizophrenic class of no disability. That doesn't mean all life though.

Q But P.A. I was a patient who apparently couldn't be discharged until they stopped the drugs. Isn't the right?

A I don't know.

Q Did you testify that you frequently are able to discontinue neuroleptic drugs for the patients who come into your ward from psychiatric wards?

A I discontinue all neuroleptic drugs. Then after [illegible] very few are put back on a very minimal [illegible] discontinue all kinds of polypharmacy.

Q What drug combinations are you thinking of when you talk about polypharmacy, more than one neuroleptic?

A Oh, yes. Polypharmacy is more than one drug. And the basis of good medicine is that you should use one drug if need be if that does the job. That's the only reason why you should not use any amount of combination. For the simple reason, when you use the combination and something goes wrong, you don't know which drug did it, whether to combine -- whether a combination did it or a single drug. So, it's safe, it's effective medical care using only one drug at a time. Now, there are very few indications where you have to use polypharmacy. However, when the indication is present, it is best to use the minimal amount of dosage of each drug.

Q Do some patients come to you from other wards receiving more than one neuroleptic drug?

A Yes.

Q Do you look at the charts for these patients to see if there is a rationale for using more than one?

A Definitely.

Q Do you ever find cases where you can't see rationale?

A Many.

Q Do you ever find a case where you do see a

carbonate?

A. Very few.

Q. Do you know whether when the patients are transferred from your ward to the psychiatric ward, whether your drug prescription practices are continued or whether the polypharmacies resume?

A. I don't know definitively, but in my opinion and assumption, I don't think most of it are followed. And my staff is told very emphatically that they should write down in writing their recommendations and what drugs or what drugs should be had for this resident. Now, the reason why I say I don't know definitively, because many times we get patients returned in a matter of days or three weeks and they're really decompensated and new drugs are given to them.

Q. Dr. Lo Prete, have you ever had at Ancora hospital a patient whose medical problem resulted from neuroleptic doses, in your opinion?

A. Oh, sure, sure. I mean, you take tardive dyskinesia, that's a medical problem. If you want to categorize it as, it's a neurological problem, but every problem is in the realm of philosophy of the human being medical problem.

Q. Did you see such tardive dyskinesia in the hospital?



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Q Dr. Lo Preto, have you ever had a patient who was sent to your ward because of a medical problem which was caused by drugs?

A Yes.

Q What have those problems been?

A The side effects and -- well, let me see. There are two classes. One of the side effects of the neuroleptic drugs which are anything from dystonic effects, akathisias. That's one class. Then another class is frank toxicity, somnolence, obundation and coma.

Q You had patients come in in a drug induced coma?

A Yes.

Q How often does that happen?

A Infrequently, but, you know, let me express a little philosophy here. If you have a million deaths, sure, it's a catastrophe. But if you have a single death it is a tragedy. So, if I had one coma in a year, I'm not right. It's a lack of judgment.

Q Did you have a coma that year?

A Yes.

Q Who is that patient?

A I, I couldn't tell you the name. We have a rapid turnover [illegible] most of the patients that we do have [illegible] would be the geriatric residents and

neuroleptics were very end.

Q Would you describe about once a year you have a patient come in in a drug-induced coma. Is that accurate?

A Yes, it's accurate.

Q What is the treatment for the drug-induced coma?

A Treatment? Hopefully if you know the drugs that was administered, which I think you should from the pharm, after a very careful evaluation, the treatment is -- to see if you can drug that drug out of the system. And usually, they're not suicidal attempts but usually it's to make the renal status, you know, urinate as much as possible. And supportive cardiac and respiratory supports.

Q Those are cases in which the patient went into coma only taking the amount of drug prescribed by the physician. Isn't that right?

A That's right.

Q Is there any medical follow-up of these cases? Do you have staff meetings to see what went wrong when something like this occurs?

A There is the morbidity-mortality committee. That committee would take care of what we feel inappropriate. And then in our

pharmacy committee, which I chair, since I've been here for over two years now, every time I get involved in a statement of polypharmacy, drugs are dangerous, you have to use the judiciously in that nature.

Q Incidentally, Doctor, as a result of your educational efforts have you noticed the decline in the use of polypharmacy?

A I prefer not to answer that. I don't want to get subjective because I don't think that's in my germane. I think it's the medical director's responsibilities. The nurse he gets the information.

Q Let me ask it this way, Doctor. Are you confident that there has been a decrease in polypharmacy because of your educational efforts?

A Unfortunately, no. No, I'm not confident. You see, may I explain for a second?

Q Please.

A Yes, the use of polypharmacy has a lot of facets to it. First, you deal with the nature of the drugs. Is the individual who prescribes those drugs know the effectiveness, the potentiality, the side effects? Number two, is the individual competent in taking care of certain cases? And number three, do the nurses give that information to me?

Q Do you ever come across instances in which

the nurses gave something other than what the doctor
had ordered?

A No, I haven't, but I'm only on Unit 3 where I am
not a policeman, but I'm highly motivated with integrity
and knowledge and I see to it that my staff does things
as perfectly as they can. But I've heard in instances
where these things have resulted and I'm not too
thrilled in hearing that.

Q Dr. Lo Prete, if you've had these drug-induced
coma patients survived, haven't they responded to your
treatment?

A Sure.

Q You then send them back to the psychiatric
ward?

A You see, the function of the medical surgical
unit is to take care of any acute medical or surgical
problems and then as soon as they're stabilized, they're
sent back to their therapeutic modality where hopefully
they can be discharged.

Q Have you ever followed-up on one of these
drug-induced coma cases to see whether the ward
got discharged?

A The only follow-up we had, we have medical clinics
[illegible] and when we see these people back,
[illegible] have the patient or resident

at the medical clinic for a follow-up. But I have no
I have no way of knowing whether they have or not.
know. The only way I know is sometimes when you get
a recidivistic patient, that about two weeks later
they come back to our unit again with the same problem
and then we can assume that they haven't, you know.

Q Does that happen with the drug-induced coma
cases?

A No, sir, you're harping on this drug-induced
coma as if this was a frequent thing.

Q Please just answer the question, Doctor.
already testified how rare it is.

Okay. Let's have the question more simply and
objective and I will gladly answer it.

MR. GELMAN: Mr. Wallach, would you please
instruct Dr. Lo Preste that I can ask him
speculative questions.

MR. WALLACH: Why don't we go off the
record for a minute and maybe I'll talk to
Dr. Lo Preste for a second?

MR. GELMAN: I would object to you going
off the record to talk to Dr. Lo Preste.

MR. WALLACH: Okay. Then you ask him
any questions you want. I won't say a word

MR. GRIMM: Please read back the last question.

(Thereupon, the pending question is read by the reporter.)

Q Okay. I will rephrase that question.

Mr. Lo Prete, has it ever happened in your experience that a patient who went into a drug-induced coma because of a certain treatment regimen was returned to the psychiatric ward and then came back to your ward in another drug-induced coma because precisely the same treatment had been followed?

A No, not that I'm aware of.

Q What other medical problems do you see that are caused by neuroleptic drugs, medical problems you see on your ward?

A Sure. One is a serious thing, i.e. dehydration, loss of appetite.

Q How prevalent is that?

From the geriatric ward, gee whiz, I would say that's fairly prevalent. You know, it's not -- hopefully, most noncompliance. But, did I say 30 percent? Did you want -- I'd say 30 percent.

Q 30 percent of the geriatric patients are -- that it?

A Question is what do I see?

Q Yes.

Yes, about 90 percent of the people coming into our unit. You see what I mean? You can't make a statement that 90 percent -- maybe there's more. Good God [illegible]. I hope somebody would look at me. Now, people, into our unit, now dehydration, there is [illegible].

Q How prevalent is that?

Sedation is quite prevalent. And then these people fall. As a consequence of this, the other complications are broken bones.

Q How frequently would you say people fall because of neuroleptic drugs?

I can only answer that in the geriatric population, in all psychiatric state hospitals, may I say that?

Q Yes.

But I think a good 50 percent, there is, you know. They think you're in a hospital to have drugs and they [illegible] a lot of sleeping tablets and the time this [illegible] is when a little old man and little old ladies [illegible] in the early morning and fall.

Q Do neuroleptic drugs cause this?

Yes.

Q Most of your neuroleptic drugs are prone [illegible]?

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A Well, you have five classifications of neuroleptic drugs, but I think the culprit is classification of the phenothiazines.

Q Dr. Lo Preste, what other medical complications from neuroleptic drugs do you see?

A Well, those are the most serious. Then you see simple side effects, you know.

Q Such as?

A Well, you may have hyperirritability or you may have a mild retardation. See, now, those things may not be serious, especially in a young person it's not. But you take a geriatric classification, well, that could be serious.

Q How prevalent are those conditions?

A I think they're pretty prevalent in geriatrics.

Q Can you say how prevalent they are in non-geriatric classifications that receive neuroleptic drugs?

A Let's say this: In the non-geriatric, if I can put it in percentage-wise, I think it's about anywhere from 10 to 20 percent, you know. But with the geriatric population, you're going -- there's 50 percent or more.

Q Is either hyperirritability or mild retardation?

A Yeah.

Q Are other medical complications, however

rate of frequent?

A Well, you see, the other complications are a consequence of these, which are the most serious.

Q What are the secondary complications?

A The secondary would be pneumonias, infectious processes in the lungs.

Q Very briefly, Doctor, for my benefit, very briefly, what is the mechanism by which a pneumonia could be produced?

A Well, the physiology of the lung is to contract and expand. Okay. So, we call that your toilet. So if they cough they can spill out bugs, bacteria, get rid of that clean and open. Now, if you're dehydrated and you're sedated at the same time, you're not going to have normal pulmonary physiology. Instead of breathing normally 16 per minute, you may breathe five per minute and whatever is pathological down there is going to grow bacteria like mania.

Q Another form of complication?

A Well, we had the lung. Then when you have severe dehydration you get renal shutdown and from the renal shutdown if you're not putting out urine, you're going to have toxic effects in the whole body.

Q Is that, and you, off the top of your head, incidence of such, pneumonia in the

general population?

A General population incidence?

Q Yes.

For what ages? There's a difference.

Q Let's say for all ages.

All ages in America?

Q Yes.

A I'd say it's about maybe 15 percent.

Q Fifteen percent will have it at one time or another in their lives?

A No. In their lives, let's go -- let's say about 3 percent. The whole gamut from birth to death.

Q Let's put it this way: How much more pneumonia do you see in a population that receives neuroleptic drugs?

A You have to go a little further. If you say to me how much more pneumonia do you see in a population that is treated with neuroleptic drugs, you see a hell of a lot more.

Q You mean twice as much or three times as much?

A I'd say three times, sure.

Q What about for younger persons?

No, you don't see it, you know, that often. It doesn't really increase because they have more viability.

their appetites are better, you know, they're younger.

Q What other secondary complications are there?

A That's about it in general, you know.

Q Dr. Lo Prete, what about sudden deaths in patients, can that be a consequence of neuroleptic drugs?

A Definitely.

Q Do you ever see cases in which you suspect that neuroleptic drugs caused deaths in this syndrome?

A Do I see that here?

Q Yes.

A Or in my experience?

Q Here.

A I see them, yes, but, you know, it has to be proven by an autopsy. I did two years of pathology. Now, if the pathologist doesn't have medical integrity to call shots the way he sees them, it's not going to be proven. Let me say that in general that neuroleptic drugs over a prolonged period will cut out a lot of physiological reflections. Whether they're respiratory, breathing, cardiac reflections and that's the danger.

Q It's been reported in some newspapers that [illegible] York State medical examiner thought that half of [illegible] medical deaths related to neuroleptic drugs [illegible] because the gag reflection was suppressed or

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because the patient was so sedated that he or she couldn't feel pain.

A In that general, I would agree with him, but not definitively. Let's make it more definitively, okay?

Q All right. Now --

A Now, the chronic schizophrenic, I hate the term, but that's what they throw at us. They've been taking the drug for years. Now, I think that the studies show causes of deaths for schizophrenic was choking.

Q Do you know of any studies which definitively address this problem?

A I couldn't quote you offhand but the studies have been in the literature for the past, I'd say, 30 years.

Q Dr. Lo Prete, your primary field here is not psychiatry. Isn't that right?

A I have to agree with that, but I feel -- I mean, totally qualified. But then the patients we get upstairs, naturally, basically were psychiatric patients who have had med problems. So, it behooves us to know both psychiatry and internal medicine. But my main forte, naturally, is internal medicine.

Q Are psychiatrists generally aware of the -- [illegible] effects of drugs, as you prescribed them?

[illegible] -- may I ask my lawyer something?

Q Yes.

A The question is rather general and I'd give my professional opinion.

MR. WALLACH: Ask him to make the question more specific.

THE WITNESS: Can you make it more specific?

Q Not even directed to this hospital, particularly.

A Definitely, yes.

Q Psychiatrists are aware?

A No, I'm sorry. No, I don't think they -- let's say this though. Damn it, they're trained to be aware of it but I don't see any positive thrust from that avenue. They have that M.D. They're dealing with drugs every day. But what I see is pretty -- I don't know. It's kind of shocking. I think every M.D. has a responsibility. Whether he uses aspirins or peanuts, to know the importance of what the hell he's doing.

Q Dr. Lo Prete, is there any association, formal or informal, of doctors who practice medicine or are in charge of medical wards in mental hospitals?

A Are there any associations?

Q Yes.

A Could you rephrase that because I don't understand what you're driving at. I'm a fellow of the American College of Physicians, you know.

Q Is there any medical association which is composed only of doctors who take care of the physical complaints of people who are in mental hospitals?

A No, no, not to my knowledge. If there was, I wouldn't join them any way. You have to be a total physician. I don't think so though.

Q Dr. Lo Prete, would you briefly tell me your educational background and your medical qualifications?

A Sure. I graduated from Hahnemann Medical School and I took a three-year medical residency in internal medicine and I became certified and then for about 12 years I was a medical consultant in a psychiatric facility at P.G.H. which at that time was a very glorious institution.

Q What hospital was that?

A Philadelphia General Hospital which was run by the five medical schools. And since '74 I've been a Colonel in the United States Air Force Medical Corp where I was Chief of Addiction, drug abuse and addiction and I was Chief of Medical Services.

Q Dr. Lo Prete, when a patient comes to your ward, a chart follows him or her. Isn't that right?

A Right, right.

Q And the ward physician ever record what he finds of the physical distress is?

A Be sure in hell better. Of course he does. I make rounds every morning and we spend at least an hour and an hour and a half seeing every patient after grand rounds. Then for about a half hour we have a session where we may discuss a case myself with differential diagnoses. I'll get some abstracts on the literature which is currently in the field. But every patient who comes to us, each one of my doctors must, you know -- that's a diagnosis. If it's a tentative diagnosis, how this patient got this way, what does he have, sure.

Q Let me make my question clear. Does the physician on the psychiatric ward who is sending the patients to you in the first place indicate a diagnosis, even a tentative diagnosis?

A Not always, no.

Q Sometimes they do and sometimes they don't?

A Right

Q Has any physician ever, in his diagnosis, indicated that he thought neuroleptic drugs were a [illegible] agent?

A No, no. I don't think they would.

Q Why

A That's -- they call that really, self incrimination

Q [illegible] No, I think he would be a damn fool if

he did. I wouldn't make fun of him. I would help him. I would appreciate it if they did, but they don't. They don't. Even in the Air Force they don't.

Q Have you ever taken up these problems, the problems we've been talking about in the medical committee at Ancora, for example, asking that physician?

A Yes, yes. And since I was here two and a half years I've published -- I hope this is not arrogant, but beautiful educational papers of all the medical problems we see at this hospital, pneumonias, hypertension and all. So, the education is here. It's here, you know.

Q Do your educational materials deal with the possible complications of neuroleptic drugs?

A I had one paper, you know, but all these medical syndromes, they deal with the complications, how they arise and it's more on pathophysiology. But we do deal definitively with reference to the polypharmacy in our morbidity-mortality committee and in our pharmacy committee.

Q Are there notes or minutes in the morbidity-mortality committee?

A Sure, sure.

Q Do the notes or minutes of the morbidity-mortality committee ever indicate that neuroleptic [illegible] out?

A Frequently they have, as I recall. What we have -- you see, when we have these committees that I chair, I overtly state to the secretary whether it's a doctor or a nurse, please put down what we talk about. And many times, you know, you take the minutes -- the minutes are finalized and the most important things you said are not there. I don't know why. Especially morbidity-mortality. But every death we go over every month.

Q Dr. Lo Prete, do you have any opinions on the best way to manage or control the medical complications that come from aminophenothiazines?

A Let me answer that very indirectly. And this is my whole medical career. You don't use any drug unless you know what you're doing after your evaluation. Number two, because a patient is admitted to a psychiatric hospital, that doesn't mean that they need a drug. Number three is prevention. Prevention because sometimes these drugs can kill. You can have all the expertise in the world, but you can't save them. So, it's prevention. It's a knowledge of drug. It's a respect for the drug. I suppose for definitive diagnosis and I don't have to -- everybody I see. I recommend it's work right now -- [illegible] in active practice, many patients would [illegible] to give me a prescription and it's my

you don't need any. You want to take vitamin tablets, go ahead, take it. I think this should be done.

Q What would be the best way to instill this respect for the drug, as you call it, in the perfection -- continue on education, sir. We have here and not many people attend. We have it here, and believe me, I have this hospital two and a half glorious years and I don't mean to be arrogant, but I've worked hard. I'm in my office seven o'clock and sometimes I leave at six o'clock and I believe in continuing education. But what can you do if you're going to give a lecture and you have two doctors and you have maybe a staff of 20. But, in reference to that, I think when you have a degree, whether you're a professional, whether it's a degree in law or engineering, you have a responsibility to do the best you can. And that responsibility entails flexibility, charity, courtesy, good motivation, integrity and honesty and a knowledge of what the hell you're talking. Now, I'm not saying that I know everything, but I'll admit it if I don't know -- I know where to get that knowledge. And I'd be the first guy. If they want me to talk five days a week, I'd gladly do it. But, basically, my work is team work. But once you have a decision, whether it's the medical director or what have you, we're all in trouble.

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MR. CHUMAN: I'd like to go off the record and assign a code name to a patient.

(Whereupon, a short discussion is held off the record.)

Q Dr. La Prete, are you familiar with the case of patient D.H. 1?

A I don't know her by name. Maybe if you can tell me the pathology.

Q Well, would it refresh your recollection if I told you she was a woman, 40 or maybe up to 46 years old. She died at the hospital. An autopsy was performed and no pathology was found in the body at the autopsy. Does that refresh your memory?

A Did that happen about a year and a half ago?

Q November of 1973. You're still not sure?

A I'm not sure.

Q Well, let me ask you --

A She may have had an uncle who is a dear friend of mine at John Hopkins and he called me personally.

Q Well, what happened in that case?

A Maybe it's this one, I don't know.

Q What happened in the case of the patient [illegible] called you from John Hopkins?

A Yeah, I think was the case, D.H. 1. He said, [illegible] the cause of death and I said nothing was

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friend. He said we've been friends for five years, do you think it was drug-induced and I said, off the record, yes but. But I don't know if that's the case.

That's now on the record.

Did the morbidity and mortality committee vote about the death of this woman whose uncle was at John Hopkins?

A Yes. And the uncle also called Dr. Turnier, the pathologist.

Q This uncle at John Hopkins, what position did he hold at that University?

A I think at that time he was Chief of Intensive Care Unit. He did a lot with the respiratory problems, I can recall.

Q He was the medical doctor?

A Yes.

Q What is his name?

A I forget his last name. It's John. I haven't seen him for a year and a half. I forget his last name.

Q Did the morbidity and mortality committee consider the possibility that this death was caused by neuroleptic drugs?

A Yes. That whether it was documented or not, I don't recall now. But I know definitively we did

Q But you don't know what that's in the minutes?

A That's what I mean, I couldn't tell you.

Q What was the upshot of the discussion?

A Well, that these, you know, the drugs are very dangerous, polypharmacy drugs, and there was no other conceivable cause of death, so this could possibly have been drug-related. I don't know if Dr. Turnier had any toxicological studies on the patient or not, because it's about a year and a half ago, but the upshot of the whole discussion was that it could have been a drug-induced death or related death.

Q I hope I'm not being repetitious, Doctor, but who else is on this morbidity and mortality committee at this time?

A It should be most of the assistant medical directors. I chaired them. We have a pathologist, Dr. Turnier and two doctors, Dr. Barrientos and Dr. Veloy.

Q Is the medical director a member of the morbidity and mortality committee?

A He's always invited, I'd say this.

Q He often finds it impossible to come to the meetings, is that right?

A I can't answer for him. I can only answer for myself. I'm always invited.

Q As I recall, patients who attempt suicide will

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be transferred to your ward?

A If they're a medical problem.

Q If they're a medical problem?

A Yes, yes, and then we have a one-on-one relationship, you know.

Q In your opinion, could neuroleptic drugs induce suicidal states or not?

A That's really hard to say. You have to individualize every case. In general, the answer should be no. You see, it's a very difficult thing.

Q But in some circumstances the answer would be --

A I would imagine, sure, there's never -- I would imagine, sure, it could happen.

Q Are you familiar with the case of Caroline Kanger?

A Yes, I am.

Q What was your involvement with her?

A Well, she was on our ward on two occasions and she first came to us, maybe Mrs. Cracker would know the date. About nine months ago or ten months ago. She had a very definitive medical work-up. At that time she had fluids in her abdomen. She had fluids in her chest. I think her right breast was taken off because of cancer and she was a diabetic. And we had her for about three or four weeks and oh, she did

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beautifully, and we sent her back with the recommendations I forget the unit she went to. One or two. Followed up with medical clinics. And then she came back to us about two, three months later with the same problems, same problems. And that's the last I've seen or heard of her. Then I know recently she was transferred, I think, to the Our Lady of Lourdes.

Q Did she come to you the first time with heart failure or was that a problem taken to your ward?

A No, I think her primary symptom was because of the ascitis, fluid in her abdomen and in her lung. She had respiratory distress because of that but not so much of the heart failure. And she had uncontrolled diabetes at that time.

Q Doctor, do you know whether there was any -- I withdraw that.

Dr. Lo Prete, who keeps the records of the morbidity and mortality committee at Ancora Hospital, the minutes?

A Well, they're kept -- Dr. Turnier should have a file on that. Yeah, they're kept there. I have a file in my office of all the minutes.

Q You do have all the minutes?

A Yes.

Q Going back how far?

A Well, I think it's about that thick (indicating), so, I would say at least two or three years, probably four years, you know. Let's say since '77 I know I have copies of them, yes.

MR. GELMAN: Mr. Wallach, I'd ask that those minutes be produced.

MR. WALLACH: Off the record.

(Whereupon, a short discussion is held off the record.)

MR. GELMAN: I have no further questions. I thank you for your time, Doctor. Mr. Wallach may have some questions.

THE WITNESS: Okay. Sure.

MR. WALLACH: I don't have any questions.

MR. GELMAN: Thank you.

THE WITNESS: Okay. You're welcome.

D O R O T H Y L O S A S S O, Nurse at Aucora, sworn.

DIRECT EXAMINATION BY MR. GELMAN:

Q Mrs. Lo Sasso, I am going to be asking you a series of questions this afternoon. I'd like you to answer them as directly and completely as you can. If you're not sure of what I mean, please don't hesitate to ask me for clarification. I can either rephrase the question or ask the reporter to read it back.

You are represented by Mr. Wallach this

# Opposition

ORIGINAL

NO. 81-5534

NOV 9 1981

OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

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JOHN Z. RENNIE, CAROLINE MAUGER, EUGENIO BURGEOS, LEON ROSSI, HAZEL MONCRIEF, ERNIE WELKER, MARY JANE WEISS, MARGARET MAY MC GRATH, JOSEPH KAMIENSKI, on behalf of themselves and all others similarly situated,

PETITIONERS,

v.

ANN KLEIN, Commissioner, Department of Human Services; MICHAIL ROTOV, M.D., Director of the Division of Mental Health and Hospitals; MAX PEPERNIK, M.D., Acting Medical Director at Ancora Psychiatric Hospital; ROBERT WALLIS, Chief Executive Officer at Ancora Psychiatric Hospital; ENGRACIO BALITA, CONSUELO SANTOS, VICTOR IVANOV, GERALD ABRAHAM, Assistant Medical Directors at Ancora Psychiatric Hospital,

RESPONDENTS.

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# MEMORANDUM OF RESPONSE TO PETITION FOR WRIT OF CERTIORARI

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RESPONDENTS.

MEMORANDUM OF RESPONSE TO PETITION FOR WRIT OF CERTIORARI

## COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Do involuntarily committed mental patients have a constitutional right to refuse treatment with psychotropic medication?

2. Were principles of federalism violated when the Court of Appeals refused to vacate the district court's sweeping and detailed classwide preliminary injunction, despite the complete absence of evidence in the trial record justifying such relief?

3. What procedures, if any, are required by due process when an involuntarily committed mental patient receives psychotropic medication?

## COUNTERSTATEMENT OF THE CASE

Although petitioners have accurately described the procedural history of the case, they have exaggerated and distorted the nature of their proofs and minimized the extensive testimony and evidence presented by defendants. Specifically, although petitioners did focus their presentation on medication practices in some of New Jersey's State psychiatric hospitals, their proofs consisted largely of isolated incidents of allegedly inappropriate use of antipsychotic medication.* No effort was made to present classwide proofs regarding the use of medication. Only one of petitioners' experts, Dr. Crane, did any more than see a few patients who had been preselected by the Public Advocate. However, his report was flawed because he did not obtain information on whether or not the patient had refused medication since that was "not an important issue." 4 App. 1394a-14 to 19. And he made no effort to assess whether the risks of side effects outweighed the benefits of the medication for that patient. 4 App. 1390a-25 to 1391a-11.

*In a similar fashion the district court opinion and the dissent of Circuit Judge Gibbons focused on alleged isolated failures within the overall State institutional system for the mentally ill. For example, the district court found that medication decisions are often left to nurses or even attendants. Rennie v. Klein, 476 F.Supp. 1294, 1300 (D.N.J. 1979)(Rennie II). This finding was based on testimony by a former nurse at Ancora and was limited to practices "[w]ithin her ward." XXIII T 58-20 to 59-3. No other evidence on this issue was presented by petitioners to support the court's broad finding that medication decisions are not made by staff physicians. The district court also found that the hospitals were understaffed, based on the testimony of a physician with regard to that same unit at Ancora. Id. at 1299. No testimony was presented regarding staffing shortages at any of the other four institutions. In a similar fashion, the district court made broad comments concerning the environment and treatment programs at the five hospitals based on the testimony of two people who testified with regard to one unit at Ancora and an outside expert who toured Trenton Psychiatric Hospital and admitted that he does not "believe in" state hospitals. Ibid. The district court chose to ignore the testimony of petitioners' own expert witness, Dr. Crane, who toured Ancora and Marlboro and observed that both hospitals impressed him "very favorably in terms of the lack of being overcrowded and general care that the patients were receiving and the cleanliness of the place and the spaciousness in general of the place." 3 App. 1082a-7 to 12. Dr. Crane also found the general level of care at both hospitals to be "very satisfactory." XVII T82-11 to 12.

The district court simply ignored the extensive testimony and evidence which demonstrated the independence and good faith of the Medical Directors and the staff of the central offices of the Division of Mental Health and Department of Human Services in developing (CONT.)

Furthermore, petitioners' one-sided focus on the side effects of antipsychotic medication ignores the critical importance of psychotropic medication in the treatment of psychiatric hospital patients which was acknowledged by almost every expert witness who testified in this case. See, e.g., 3 App. 1092a-11 to 14; 4 App. 1675a-4 to 12; 4 App. 1754a-20 to 1755a-5; 5 App. 2181a-12 to 13; IIT145-6 to 146-24; XI T85-16 to 19. In addition, substantial documentary evidence was introduced supporting the view that psychotropic medication is an essential part of the treatment of psychiatric hospital patients. See, e.g., Exhibits D-3 to 9, 13, 52. Based on this evidence and testimony the district court made the following findings:

> "In the past twenty years, psychotropic drugs have played an increasingly important role in the treatment of mental illness, and are now widely used. Psychotropic drugs tend to shorten hospital stays and allow patients to function in the community. Many consider use of these drugs necessary in any treatment program, especially with schizophrenics. . . . Furthermore, psychotropic drugs are required in order for some patients to effectively participate in and benefit from other types of therapy such as individual or group psychotherapy and occupational therapy . . . . In sum, psychotropic drugs are widely accepted in present psychiatric practice." Rennie v. Klein, 462 F.Supp. 1131, 1137 (D.N.J. 1978)(Rennie I).

The Court of Appeals echoed these findings and observed that:

> "The record demonstrates that these [antipsychotic] drugs can be valuable in the treatment of certain mental illnesses, relieving symptoms on a short term basis as well as for lengthy periods. Their use often makes it possible to shorten the period of confinement drastically and also makes patients more manageable and, hence, less a threat to others." Rennie v. Klein (Rennie III), 653 F.2d 836, 845 (3d Cir. 1981)(en banc).

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and implementing guidelines and procedures to protect and safeguard the statutory and constitutional rights of patients in the area of psychotropic medication. Instead the district court chose to label isolated instances of alleged misconduct and factual findings related to individual patients as an overall pattern designed to violate petitioners' constitutional rights. This was improper. Rizzo v. Goode, 423 U.S. 362, 375 (1975).

Petitioners seek to minimize this critical role of psychotropic medication in the treatment of psychiatric hospital patients by exaggerating the potential side effects of such treatment. However, such an approach ignores the testimony by petitioners' own expert witnesses that even the presence of tardive dyskinesia should not preclude the use of psychotropic medication. 3 App. 1092a-11 to 14. 5 App. 2150a-14 to 16. Furthermore, Dr. Rachlin, expert witness for defendants, testified that the psychiatric professional literature and the majority of psychiatrists practicing in the United States today support the view that the benefits of psychotropic medication clearly outweigh the risks of tardive dyskinesia. 4 App. 1787a-15 to 21; 1790a-22 to 1791a-30.

Most importantly, petitioners choose to ignore the fact that the State of New Jersey has developed an extensive series of guidelines and regulations governing the administration of psychotropic medication and the monitoring of side effects in its psychiatric hospital.* These procedures were found by the Court of Appeals to be constitutionally adequate** to "protect the patients' interests at stake." Rennie III, supra, 653 F.2d at 851. The procedures developed by the State also were praised by both petitioners' and defendants' expert witnesses.*** Thus, Dr. Gill testified that New Jersey's administrative bulletins were very useful guidelines for both the general use of medication and how to watch for and document

*The procedures developed and currently being implemented by the State include an administrative procedure to be followed whenever a patient refuses psychotropic medication (Administrative Bulletin 78-3), a series of guidelines governing the use of psychotropic medication (Administrative Order 2:13), and a set of requirements for in-service staff training in the use of psychotropic medication (Administrative Bulletin 78-6). Under the State's administrative procedures, before a patient can be medicated against his will in non-emergency situations there must be a meeting of the treatment team, followed by a personal review of the patient and his records by the Medical Director. In addition, the guidelines on psychotropic medication require the completion of the AIMS checklist every three months to monitor patients for any side effects from psychotropic medication.

**This was done "as a matter of law," 653 F.2d at 865 (Garth, C.J. concurring) because these procedures "facially comport with the requirements of procedural due process," 653 F.2d at 854 (Seitz, Ch.J., concurring).

***In addition each of the Medical Directors testified or had their depositions introduced into evidence. Each described the implementation of the State's procedures at their institution and discussed the advantages and disadvantages of this system as compared to various alternatives proposed by the district court or petitioners.

side effects. 4 App. 1708a-22 to 1709-3. Dr. Crane, expert witness for petitioners, testified that Administrative Bulletin 78-3 was "a very reasonable document" and Administrative Bulletin 78-6 was "a rather adequate and medically sound document." 4 App. 1401a-20 to 1402a-1. He stated that these procedures would be a good system if they were followed down to the level of the treating physician. 4 App. 1402a-5 to 9. Dr. Carpenter, another expert witness for petitioners, testified that the State's administrative procedures "seem to be reasonable documents" and if carried out would contrast with what ordinary practice has been in most institutions during the past ten years. 4 App. 1523a-16 to 1524a-3. Even the district court found that these guidelines are "well intentioned and reflect a reasoned approach to the use of psychotropic medication." Rennie II, supra, 476 F.Supp. at 1300. Based on these facts, eight* of the nine judges in the Court of Appeals found New Jersey's approach to the administration of psychotropic medication in its State psychiatric hospitals to be constitutionally adequate. Rennie III, supra, 653 F.2d at 851, 854 (Seitz, Ch.J. concurring), 855 (Garth, C.J. concurring). It is the position of defendants that these procedures in fact exceed any constitutional due process requirements.

*Even dissenting Circuit Judge Gibbons conceded that "[i]n the abstract" the State's procedures may satisfy constitutional standards. Rennie III, supra, 653 F.2d at 865.

## ARGUMENT

### CERTIORARI SHOULD BE GRANTED TO EXAMINE THE THIRD CIRCUIT'S ERRONEOUS CREATION OF A CONSTITUTIONAL DUE PROCESS RIGHT FOR INVOLUNTARILY COMMITTED MENTAL PATIENTS TO REFUSE ANTIPSYCHOTIC MEDICATION.

#### A. The Court of Appeals has misconstrued recent Supreme Court decisions in finding that involuntarily committed mental patients have a liberty interest in refusing antipsychotic medication.

In reaching its conclusion that the procedures adopted by the State of New Jersey to regulate the administration of psychotropic medication to State psychiatric hospital patients satisfy constitutional standards, the Court of Appeals created a qualified right to refuse antipsychotic medication based upon a liberty interest rooted in the Due Process Clause.* In establishing this right, the Court of Appeals misapplied a series of recent decisions by this Court concerning the Due Process Clause, particularly Meachum v. Fano, 427 U.S. 215 (1976); Montanye v. Haymes, 427 U.S. 236 (1976); Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1 (1979) and Vitek v. Jones, 445 U.S. 480 (1980).

Before a person can be involuntarily committed to a State psychiatric hospital in New Jersey it must be demonstrated that he is both mentally ill and dangerous to himself or others or property. New Jersey Court Rule 4:74-7; State v. Krol, 68 N.J. 236, 344 A.2d 289 (1975). Within 20 days of confinement he must receive a full court hearing with appointed counsel, if necessary, to determine whether or not "institutionalization is required by reason of his

*The court also found that any involuntary administration of those medications must be governed by the "least intrusive means standard." Rennie III, supra, 653 F.2d at 845-8. Defendants are in agreement with the position of the four concurring circuit judges that "the least restrictive alternative standard is not relevant in deciding the procedural and substantive due process issues presented by this appeal," 653 F.2d at 854 (Seitz, Ch.J., concurring), and that "concepts of least restrictive treatment and risks of side effects have no place in this constitutional analysis," 653 F.2d at 855 (Garte, C.J., concurring).

being a danger to himself or others or property if he is not so confined or treated . . ." New Jersey Court Rule 4:74-7(f). If the court finds that the person requires involuntary commitment, this decision is reviewed by the court after three months, six months and one year, and on an annual basis thereafter. Ibid. Furthermore, the patient can petition at any time for a writ of habeas corpus if he believes he is being illegally detained. N.J.S.A. 30:4-24.2h. It is thus clear that New Jersey law provides elaborate due process procedures in connection with both the initial commitment and continued confinement of a person who is mentally ill.

The governing State statutes also deal in some detail with the forms of treatment to be provided the mentally ill, the procedures which must be followed in determining which treatments to use and the delineation of specific treatments which may only be used with the patient's consent. Thus, N.J.S.A. 30:4-24.2(d)(2) provides that a patient has a right "[n]ot to be subjected to experimental research, shock treatment, psychosurgery or sterilization, without the express and informed consent of the patient after consultation with counsel or interested party of the patients' choice." On the other hand, in apparent recognition of the fact that the administration of medication represents normal and customary treatment of a person involuntarily committed to a psychiatric hospital, the governing statutes establish procedures for assuring that only proper medication is administered without requiring patient consent. N.J.S.A. 30:4-24(d)(1) provides:

> "No medication shall be administered unless at the written order of a physician. Notation of each patient's medication shall be kept in his treatment records. At least weekly, the attending physician shall review the drug regimen of each patient, under his care. All physician's orders or prescriptions shall be written with a termination date, which shall not exceed 30 days. Medications shall not be used as punishment, for the convenience of staff, as a substitute for treatment program, or in quantities that interfere with the patient's treatment program."

It is thus clear that the New Jersey Legislature has made the judgment that proper treatment of involuntarily committed mentally ill persons

may be assured without requiring either the consent of such patients or the use of quasi-judicial procedures before a refusal to consent may be overridden. See In re B, 156 N.J. Super. 231, 383 A.2d 760 (1977).

It is now firmly established that the procedural protections of the Due Process Clause do not come into play simply upon a showing that a person may be subject to "grievous loss". Meachum v. Fano, supra, 427 U.S. at 224. Thus, the determining factor in evaluating whether due process requirements apply is ". . .the nature of the interest involved rather than its weight." Id. See also Greenholtz v. Nebraska Penal Inmates, supra, 442 U.S. at 7. This means that generally a person has no liberty interest protectible under the Due Process Clause ". . .absent some right or justifiable expectation rooted in state law . . . ." Montanye v. Haymes, supra, 427 U.S. at 242.

It is clear that no such right or justifiable expectation rooted in State law may be found in the present case. On the contrary, State law contains its own procedures designed to assure that mentally ill patients receive proper medication. These procedures rely on the expert medical judgment of the treating physician and appropriate medical records rather than invoking quasi-judicial proceedings.

It is also now a firmly established part of Due Process jurisprudence that where a person has been confined in accordance with appropriate procedural protections, the purposes for which that confinement has been ordered may be carried out without further proceedings. Thus, a state may not convict a person of a crime without complying fully with the mandates of due process. A conviction, however, substantially extinguishes previously enjoyed liberty interests:

> "[G]iven a valid conviction, the criminal defendant has been constitutionally deprived of his liberty to the extent that the State may confine him and subject him to the rules of its prison system so long as the conditions of confinement do not otherwise violate the Constitution." Meachum v. Fano, supra, 427 U.S. at 224.

See also Greenholtz v. Nebraska Penal Inmates, supra, 442 U.S. at 7; Montanye v. Haymes, supra, 427 U.S. at 242.

A person involuntarily committed to an institution for the mentally ill is in a comparable position. It is readily apparent that when a treating physician decides that a mentally ill patient is in need of medication that person has already received a full due process hearing in order to protect his liberty interest in not being involuntarily confined illegally. Furthermore, the continued need for that involuntary confinement is reviewed on a periodic basis by a court. However, a person so confined is not entitled to have every treatment decision made by the attending physicians subjected to further procedural requirements. Rather, the authorization for the mentally ill person to be treated in the customary manner for his illness is inherent in the commitment order.

The recent decision of this Court in Vitek v. Jones, supra, buttresses defendants' conclusion that no liberty interest is implicated when an involuntarily committed mental patient refuses antipsychotic medication. In Vitek, this Court held that before a state prison inmate was transferred to a psychiatric hospital he was entitled to a hearing before an independent hearing officer. The Court found that under Nebraska law "a prisoner could reasonably expect that he would not be transferred to a mental hospital without a finding that he was suffering from a mental illness for which he could not secure adequate treatment in the correctional facility." 445 U.S. at 488. This expectation created a liberty interest which entitled the prisoner to procedural due process before a transfer could be effected. However, an involuntarily committed mental patient is in a totally different posture than the prisoner in Vitek. As discussed at length supra, the patient has already received a full due process hearing before a count with appointed counsel and both New Jersey statutes and case law contemplate forcible medication. Thus Vitek and the line of Supreme Court cases examining the Due Process Clause support defendants' position that an involuntarily committed mental patient has no constitutional right to refuse psychotropic medication which is a necessary part of his treatment program once he has been involuntarily committed.

B. Certiorari should be granted because the record in this case focuses on procedures and other evidence which will greatly assist this court in addressing the difficult issues posed in Rogers v. Okin.

Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980), cert. granted, 101 S.Ct. 1972 (1981), poses the question of "[u]nder what circumstances may State officials forcibly administer antipsychotic drugs to mental patients without violating the Fourteenth Amendment." 634 F.2d at 653. As petitioners correctly point out this case presents that question* in a class action involving approximately 4,000 adult patients in New Jersey's five State psychiatric hospitals. Following 33 days of hearings which included testimony by 18 expert witnesses, almost all of whom were psychiatrists, the district court imposed a complex, highly intrusive, and costly system upon the State, to be followed whenever psychotropic medication was administered. The district court refused to permit the State to continue implementing its own system of administrative regulations and guidelines, despite extensive testimony by both petitioners' and defendants' experts praising these procedures. On appeal, the Third Circuit modified the district court's injunction and ordered the State to follow its own procedures, holding that this approach met constitutional standards.

Thus, this case provides an extensive record for evaluating various possible procedures to be followed when psychotropic medication is administered in a state psychiatric hospital. Specifically, this record includes cost estimates of a system of hearings with appointed counsel (similar to the approach of the district court in Rogers v. Okin, 478 F.Supp. 1342 (D.Mass. 1979)), expert testimony regarding that approach as well as with respect to the use of guardians, and, most importantly, extensive testimony

*The second question posed by Rogers focuses on the First Circuit's refusal to permit the state to develop its own procedural mechanisms for implementing a right to refuse medication. This case presents that issue even more dramatically since the State had developed a set of innovative procedures which not only exceed this Court's guidelines in Parham v. J.R., 442 U.S. 584 (1979), but are generally consistent with the guidelines set forth by the First Circuit in Rogers. It is defendants' position that the Court of Appeals erred in refusing to vacate the district court injunction, despite the absence of evidence in the record justifying any classwide injunctive relief. Rizzo v. Goode, supra, 423 U.S. at 375.

and evidence with regard to the set of procedures developed and implemented in New Jersey to regulate the use of psychotropic medication. The record also includes testimony by the Medical Director of each hospital as to the effectiveness of these procedures and the problems which would occur if a different approach were utilized.

This extensive evidence on various possible procedures to be used when psychotropic medication is administered will be particularly helpful to the Court in this case since the First Circuit has observed that the parties in Rogers advanced only "absolutist positions." 634 F.2d at 664. The Rennie trial record and New Jersey's approach to the administration of psychotropic medication which was adopted by the Court of Appeals will enable this Court to assess* the range of options available in this difficult and controversial area and thus should enhance the Court's ability to reach a result which will protect the rights of the mentally ill against inappropriate psychiatric treatment and yet not prevent the State psychiatric hospitals from providing necessary treatment to their patients.

In sum, because of the similarity of issues between this case and Rogers, and because of the important additional evidence presented in this case with respect to possible approaches to the administration of psychotropic medication in a state psychiatric hospital setting, this Court should grant certiorari now so that this case can be heard in tandem with Rogers.

*Thus, if this Court should find that there is a limited constitutional right to refuse psychotropic medication, then Rennie provides a range of alternative procedures which can be measured against the factors which this Court has said must be considered in determining what process is due. See, e.g., Mathews v. Eldridge, 424 U.S. 319, 335 (1976). Defendants submit that New Jersey's procedures exceed any constitutional requirements in this area.

## CONCLUSION

For the foregoing reasons it is respectfully submitted that certiorari be granted on the questions presented herein.

Respectfully submitted,

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